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# INTERNATIONAL REVIEW

## OF THE RED CROSS



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## HEALTH PROTECTION AND MEDICAL ASSISTANCE IN DISASTER SITUATIONS

### INTRODUCTION

*In the natural and man-made disasters — including armed conflicts — of recent years, civilians have become the main victims, though in armed conflict they are neither the cause of contention nor the potential gain. Whatever the type of disaster, the most vulnerable sections of the population are those hardest hit, whose health and dignity are most severely impaired, especially in parts of the world where famine and poverty are rife.*

*The direct and “incidental” damage inflicted upon the civilian population when military operations are conducted without regard for humanitarian considerations and heedless of the rules of law, and the limited effects of dispersed humanitarian assistance provided with inadequate or inefficient supervision, are a constant reproach to the conscience of the international community and continue to place a heavy strain on the components of the Red Cross and the Red Crescent Movement in their work to protect and assist the victims.*

*These alarming developments will be examined at the forthcoming International Conference of the Red Cross and Red Crescent, to be held in Budapest in late November. The Review is therefore presenting a series of articles on the problems of providing protection and assistance — particularly in the area of health care — to the victims of armed conflict and natural disaster. By publishing the views of experts from inside and outside the Movement, the Review hopes to make a contribution to the discussion. At the same time, through its section on the humanitarian policy and operational activities of the ICRC, it would like to give greater insight into the work of ICRC doctors and teams of experts in the field by describing the difficulties they must overcome day by day and the lessons they draw from their experience.*

\* \* \*

*In the spring of 1991, the ICRC organized a seminar entitled "Famine and War" (see the summarized proceedings on pp. 549-557). The participants noted a frequent tendency for belligerents to destroy the civilian population's means of subsistence instead of confining themselves to attacks on military objectives. Deliberate acts are still all too often responsible for the loss of access to resources and the resultant destitution. Thus war both contributes to the onset of famine and limits the possibilities of combatting it.*

*To what extent does international humanitarian law prohibit such acts and, more generally, is it properly adapted to the new problems that have emerged of providing humanitarian assistance in armed conflicts?*

*In his study on protection of the civilian population, including humanitarian assistance, (see pp. 440-459), a lawyer who specializes in such assistance shows that international humanitarian law provides clear solutions prohibiting both the starvation of civilians as a method of warfare and attacks on objects indispensable to their survival. Yet these mandatory rules do not always resist the onslaught of reality, since belligerents have great difficulty in viewing the civilian population and the assistance to which it is entitled as being entirely separate from military considerations. Similarly, in his examination of three interdependent factors relating to humanitarian assistance (consent by the authorities, access to victims and proper control over the operations) the author stresses the difficulty of putting the law into effect, in view of the realities of modern war and the complexities of relief action and its coordination. For example, the law as it stands does not provide a definition of humanitarian and impartial action, thus leaving States some freedom of interpretation which can lead to abuse. On the other hand, since blockades remain permissible, even vis-à-vis civilians, important practical problems arise with regard to control over the distribution of foodstuffs and other essentials which must nevertheless be allowed entry for the sole benefit of the civilian population. The terms and conditions of control should thus be reconsidered, as should the very principle of imposing a blockade on foodstuffs.*

*The author feels that all these problems require further development of the law, and indeed a number of studies have been carried out and proposals made by international organizations and the academic world (see comprehensive account list on pp. 458-459).*

*It cannot be stressed too much, however, that humanitarian law already affords civilians substantial protection. Most urgently needed is actual **compliance** with the existing provisions of humanitarian law. Everything must be done to safeguard the self-sufficiency (and this*

includes the **dignity**) of the civilian population. The Review will come back to this subject in the future.

\* \* \*

*As a neutral and independent organization, the ICRC has a very specific role to play in preserving public health in the event of armed conflict. The mandate entrusted to it by the States party to the Geneva Conventions and their Additional Protocols, its right of initiative and its role as a neutral intermediary give it great latitude in its approach to health problems and allow it to go beyond the classic medical assistance which other organizations are also able to provide.*

*The medical work of the ICRC nevertheless faces many obstacles. How can the institution discharge its mandate when its delegates find that people's basic needs are not being met by local services for political or economic reasons, or when the authorities refuse them access to the victims? What has it done to adapt its assistance strategy to ensure that those activities compensate for any inadequacies in its protection work?*

*In a series of articles providing specific examples and statistics (see pp. 460-512), the ICRC's Chief Medical Officer and several members of the Medical Division show how the ICRC provides protection and assistance via its various medical activities.*

*To safeguard the health of the victims of armed conflict, the ICRC takes action in three ways. First, it provides direct medical care when local medical services and staff are inadequate. Over the past decade especially, the ICRC has built up its own surgical capacity to give wounded people the care that the authorities are unable to provide. The same approach has been taken to orthopaedic rehabilitation and the ICRC has set up programmes in fourteen countries to provide prostheses and orthoses using technologies appropriate to the country concerned.*

*Secondly, the ICRC gives a material and moral boost by helping local resources and services to recover their viability and thus restores life and hope to the community.*

*The ICRC's particular capacity to negotiate with the authorities is the most unique aspect of its work. Persuasion remains the best means of mitigating the effects of constraints of all kinds, and especially of handling problems concerning health care for the most vulnerable sections of the population, assistance to displaced persons and above all access to conflict zones. The main thing is for ICRC delegates to*

*be able to be present everywhere and at all times. The article on visits to prisoners by ICRC doctors (see pp. 469-482) shows how perceptive they must be, in conversation with those they meet, in order to find what really lies behind any shortcomings they observe and be able, on the basis of their own expert knowledge, to substantiate allegations of ill-treatment. Above all, they must maintain a dialogue with the responsible authorities in order to find specific solutions to specific problems, and a dialogue with the prisoners to be able to reassure and advise them.*

\* \* \*

*It is now generally recognized that the often unbridled and over-publicized international assistance that floods in after disasters is not a panacea and can even be counter-productive, bringing about a state of sustained dependency which, apart from anything else, seriously undermines the recipients' dignity and self-respect. How can the international community, in particular the various components of the Movement, come to terms with these problems and improve preventive measures by gaining a better understanding of the effects of certain human activities on the environment and the way in which such activities can trigger off disasters? Above all, how can community participation be developed and the appropriate staff be trained to deal with disasters and their consequences?*

*The head of training at the ICRC's Medical Division describes the institution's assistance strategy (see pp. 494-504), which gives local communities and their institutions a leading role in dealing with disasters so that outside aid serves only to strengthen them, not to replace them. This approach is also advocated by an expert from the Pan American Health Organization, the World Health Organization's Regional Office for the Americas, who cites his experience to show that, after having for too long harboured preconceived ideas about relief work, the international community has revised its priorities over the past few years and now stresses disaster preparedness, improvements in local health services and economic development in vulnerable areas (see pp. 513-523). The more thorough the preparations taken by the local communities and health services, the more effective emergency action will be.*

*The head of the Health Department of the League of Red Cross and Red Crescent Societies takes a similar position, advocating the community approach to health care in disaster situations and*



*explaining how the National Red Cross and Red Crescent Societies and the League, their federation, can help promote that approach (see pp. 524-532).*

*But, more than ever, the key to truly effective protection and assistance is adequate preparation and training of volunteers and specialists. Many National Societies have stepped up their training programmes in order to enable their volunteers to take action in the event of emergency and also deal with more general health problems. Likewise, the ICRC's Medical Division has been giving courses since 1986 to prepare executive medical staff to take part in emergency programmes launched by the ICRC or other humanitarian organizations (see pp. 505-512). This is no small matter, since the goal is nothing less than to reconcile the increasing professionalism of relief work with the Red Cross/Red Crescent ideal of spontaneous humanitarian assistance.*

### ***The Review***

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# Protection of the civilian population and the prohibition of starvation as a method of warfare

## *DRAFT TEXTS ON INTERNATIONAL HUMANITARIAN ASSISTANCE*

by Peter Macalister-Smith

Armed conflict is often accompanied or followed by the outbreak of famine. The legal foundations of global humanitarian policy for dealing with famine are reviewed in this article, with special attention to conflict situations and their aftermath. The existing law is examined first, and then recent proposals in the form of drafts and expert studies which seek to develop legal instruments or policy relating to international humanitarian assistance are considered.

### **1. Introduction**

The international humanitarian law of armed conflict, in treaty form, consisting of the four Geneva Conventions of 1949 and the two Additional Protocols of 1977, is widely recognized to be both a special and an important branch of public international law. The humanitarian law of armed conflict sets human values in the forefront and legally enshrines the principle that respect is owed to the human person in all circumstances. Yet the dangers to which civilians are exposed during armed conflict and in its wake have not been eliminated. It is well known that great suffering is frequently inflicted on the civilian population, and the international humanitarian response is often inadequate.

The remarks below concentrate on the law as it stands in the Geneva Conventions and in their Additional Protocols. Of course, ratifications and accessions alone do not guarantee that humanitarian prin-

ciples are in fact upheld or that people in need are always cared for. Implementation of the law is an important and related factor, but further consideration of this subject has been excluded from the present inquiry. Simply because the humanitarian law of armed conflict has been so widely accepted, it seems appropriate to review the contents of the existing law, having regard to the objective of attaining better standards of protection through the formulation of improved international humanitarian policy.

## **2. Protection of the civilian population**

In armed conflict, every belligerent seeks to win, and military force is applied for this purpose. The law, however, seeks to introduce humanitarian considerations and it may do this best wherever military requirements can give way. As is often said, the law of armed conflict must achieve a compromise between military requirements and humanitarian considerations. If this is true, and the legal humanitarian sphere is to be extended, then it is necessary to find and define new areas where military requirements can give way without the loss of overriding military advantage.

Against a background of changing circumstances, accompanied by shifting nuances of advantage and disadvantage, it may still be possible to find such areas and to agree on ways and means of defining them. Such a process underlies the development of humanitarian law from its early days, in the 19th century, dealing first of all with the care of the wounded and sick members of armed forces, then going on to cover protection of and care for prisoners of war, and again expanding to give increasing attention to protection of and assistance for civilians.

Behind these developments is the basic principle that belligerents cannot legally employ every possible means to injure and defeat the enemy. Concerning the situation of the civilian population, a distinction was made between combatants and the victims of armed conflict or those not taking part in hostilities, including civilians. It need hardly be added that the distinction between combatants and civilians has often been disregarded or abused in practice. As a legal principle it was codified only in Article 48 of Additional Protocol I of 1977, which lays down the basic rule as follows:

*"In order to ensure respect for and protection of the civilian population and civilian objects, the Parties to the conflict shall at all times*

*distinguish between the civilian population and combatants and between civilian objects and military objectives and accordingly shall direct their operations only against military objectives.”*

Additional Protocol I thus represented a great advance in this area of law. However, even a provision such as that just quoted cannot fully guarantee protection for the civilian population. One problem is that in modern warfare virtually the whole of enemy territory, including almost all the economic infrastructure, has come to be regarded as a legitimate military target. Massive aerial bombardments may take place in the interior of a country and far removed from the attacking ground forces. This recognized means of long-range warfare, as witnessed during the Gulf conflict, can disable opposing forces, weaken them or even bring about their defeat without the greater hazards of occupation by land. As a consequence, however, the distinction between military and non-military objectives is obscured. Furthermore, during attacks on legitimate military targets, inflicting a certain degree of incidental damage on the civilian population is not in breach of the law, unless the damage is excessive in relation to the “concrete and direct military advantage anticipated”: this rule was included in Additional Protocol I (Art. 57 (2) (a) (iii)). However, indiscriminate attacks are clearly prohibited (Art. 51 (4)).

While the recent conflict has demonstrated that weapons of ever greater accuracy can be developed, it has proved illusory to suppose that as a result the civilian population will be spared. Because military objectives can include almost any type of object under given circumstances—and they are defined widely in Additional Protocol I itself (Art. 52 (2))—this concept was balanced there by defining more closely the notions of *civilians* (Art. 50 (1)), *civilian population* (Art. 50 (2)) and *civilian objects* (Art. 52 (1)). Civilians are defined as persons who are not members of armed forces; in cases of doubt a person shall be considered to be a civilian (Art. 50). Civilian objects are defined as “all objects which are not military objectives...” (Art. 52 (1)).

For the first time in treaty law, both attacks and reprisals against civilian objects are explicitly prohibited by Additional Protocol I. In case of doubt, the presumption is in favour of civilian objects (Art. 52 (3)). The real difficulty, however, is that the definition of military objectives is neither strict nor comprehensive. Indeed, the definition of objects leaves room for a certain freedom of interpretation, and is couched in terms of “military advantage” to be gained (Art. 52 (2)). These provisions, relating to what is military and what is civilian, thus

operate in combination. In dealing with non-international conflicts, Additional Protocol II contains no detailed rules such as those just mentioned.

### 3. The prohibition of starvation

The borderline between military objectives and civilian objects is thus somewhat vague under the law as it currently stands. This fact, however, seems to reflect military reality. Objects which, under normal circumstances, are purely civilian objects, even including crops and agricultural land, may legally become military objectives if a party to a conflict uses them for military purposes.

Although it would seem that general and absolute protection is difficult or even impossible to attain, certain civilian objects are accorded special protection by the law, especially by the Additional Protocols. In particular, the important Article 54 of Additional Protocol I protects objects regarded as indispensable to the survival of the civilian population. The basic principle is set out in Article 54 (1) as follows:

*“Starvation of civilians as a method of warfare is prohibited”.*

This very specific prohibition is simple, clear and absolute. A corresponding provision is found in Additional Protocol II with respect to non-international conflicts (Art. 14). However, under these provisions, the starvation of military personnel remains a legitimate method of warfare. This fact can have detrimental consequences for the civilian population and constitutes a notable weakness in the present state of the law.

The remainder of Article 54 of Additional Protocol I develops the basic principle by describing and prohibiting the most usual forms of attack that can lead to starvation of civilians. The full text of Article 54 (2) provides as follows:

*“It is prohibited to attack, destroy, remove or render useless objects indispensable to the survival of the civilian population, such as foodstuffs, agricultural areas for the production of foodstuffs, crops, livestock, drinking water installations and supplies and irrigation works, for the specific purpose of denying them for their sustenance value to the civilian population or to the adverse Party, whatever the motive, whether in order to starve out civilians, to cause them to move away, or for any other motive”.*

This part of the article seeks to supply the detailed examples necessary to cover all eventualities. The objects indicated are accorded legal protection not only to ensure the survival of the civilian population as such, but also to prevent population displacements which expose civilians to especially high risk. The legal and factual protection of the fixed civilian objects and installations mentioned, such as agricultural areas, crops, storehouses and drinking water stations which cannot be moved or removed in time of attack, is of particular importance. Simply because they cannot be moved out of the zone of conflict, the only available protection is to prohibit attacks against them, and such a prohibition is found in Article 54.

Even these provisions are not absolute, however. A final clause in the same article allows for derogation from the prohibitions contained in Article 54 (2) in defence of national territory against invasion, "where required by imperative military necessity" (Art. 54 (5)). In other words, the provisions quoted with regard to civilian objects do not apply to the actions of a State on its own territory when defending itself against invasion. Furthermore, the article makes it clear that some foodstuffs and supplies may be used solely for the members of armed forces or in direct support of military action; in this case, the prohibition of attacks is weakened or becomes inapplicable. However, a fair reading of the whole article seems to indicate that at least the absolute prohibition of starvation of civilians as a method of warfare remains unrestricted, as expressed in the first paragraph.

Regarding non-international conflicts, it is important to note that the basic prohibition of starvation of civilians "as a method of combat" is also included in Additional Protocol II (Art. 14). Nevertheless, several of the supplementary rules found in Additional Protocol I are not included in the shorter instrument. While the provisions contained in Additional Protocol II are in essence comparable with those quoted above, and also include protection of objects indispensable to the survival of the civilian population, they are certainly reduced and simplified. However, the ICRC *Commentary on the Additional Protocols* rightly describes the relevant provisions in Additional Protocol II as a specific application of the general obligation of the Parties to the 1949 Geneva Conventions to guarantee humane treatment in all circumstances to persons taking no active part in hostilities (Geneva Conventions (GC), Common Art. 3)<sup>1</sup>. The basic underlying rules

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<sup>1</sup> *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, Eds. Y. Sandoz, C. Swinarski and B. Zimmermann, ICRC, Martinus Nijhoff Publishers, Geneva, 1987, paras. 4790-4813, pp. 1455-1460.

expressed in the older conventions still apply, notwithstanding the difficulty of specifying the obligations in greater detail in the more recent law.

The ICRC *Commentary* also points out that Additional Protocol I did not change the law of naval blockade (Art. 49 (3))<sup>2</sup>. Blockade is a controversial matter, and its legal aspects will not be examined here in any detail. Nevertheless, the question cannot be ignored, because international law permits the imposition of a blockade on an enemy. Various aspects may be involved; a blockade may be a collective measure, or a sanction employed in a confrontation between States of unequal strength. It is admissible under Article 42 of the United Nations Charter. It may be an aspect of economic warfare. In armed conflict a blockade is a form of siege, intended to interrupt transportation and facilitate the defeat of the enemy by cutting off supplies. In whatever form it appears, a blockade usually has consequences that are not restricted to government or military objectives but also affect the civilian population. In fact, civilians are often the principal victims of such a measure, since they may have the lowest priority in the distribution of food supplies. In practice, during hostilities the places under blockade or siege are often regarded as a single military objective; thus, despite the prohibition of indiscriminate attacks, civilians can easily become the victims of starvation, even when passage is provided for medical consignments or relief (cf. GC IV, Art. 23; AP I, Art. 70; AP II, Art. 18 (2))<sup>3</sup>.

To summarize at this point, two important legal prohibitions have been considered: the prohibition of starvation of civilians as a method of warfare, and the prohibition of attacks on civilian objects which are indispensable for the survival of the civilian population. When these protective measures have failed, relief actions are necessary. The provision of humanitarian assistance to the needy, the victims and the survivors is also an important method of giving substance to the principle of protection of the civilian population. Albeit belated and often inadequate, assistance is thus the active counterpart of protection. The concepts of protection and humanitarian assistance are closely related and complementary, as is often demonstrated in the working experience of an institution such as the International Committee of the Red Cross.

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<sup>2</sup> *Ibid.*, paras. 1895-1896, p. 606.

<sup>3</sup> GC: Geneva Convention; AP: Additional Protocol.

#### **4. Humanitarian assistance: the legal foundations**

Recent conflicts have again shown how seriously the civilian population can be affected, directly or indirectly, and how sudden and urgent the need for assistance can be. The subject of humanitarian assistance to civilians under the international humanitarian law of armed conflict should therefore be examined in greater detail. Only a brief review of this wide subject can be undertaken here, concentrating first on the established legal foundations.

The terms employed by the Geneva Conventions and Additional Protocols are usually “relief” or “relief actions”. Nevertheless, wherever these expressions are not explicitly required by the context, the terms “humanitarian assistance” or “humanitarian assistance operations” will be preferred here. The word “relief” has possible negative overtones, whereas the more correct and neutral description “humanitarian assistance” is already in widespread use and its further application should become a standardized feature of the international vocabulary.

The earlier law, the Fourth Geneva Convention of 1949, contains two different approaches to humanitarian assistance in favour of the civilian population. One general article stipulates the free passage of certain consignments (GC IV, Part II, Art. 23). A group of more specific articles covers relief in occupied territory (GC IV, Part III, Arts. 59-62). The article dealing with consignments is limited and restrictive; and Occupying Powers are made responsible for “ensuring the food and medical supplies” of the civilian population in occupied territory (GC IV, Art. 55). The Fourth Geneva Convention does not create a clear obligation to undertake assistance operations although Article 59 is worded in a more imperative way than the other provisions.

The deficiencies in the Geneva Conventions’ provisions relating to humanitarian assistance are to some extent remedied by Additional Protocol I of 1977 (Art. 70). However, it must be recalled that the Additional Protocols have not been ratified as widely as the Geneva Conventions. Thus for some States the old law still applies, while for other States the more recent instruments supply the applicable legal rules. Moreover, the Protocols cannot be said to provide all the solutions to contemporary problems of humanitarian assistance. Where the law is weak, or cannot strictly be applied at all, even emphasis rightly placed on better implementation or positive interpretation may well be incapable of bringing about substantial improvements in practice.



Article 70 of Additional Protocol I provides that relief actions for the civilian population "shall be undertaken". This form of wording, it has been commented, could imply a duty for the Parties to the Protocols that are in a position to do so to undertake or to contribute to such actions in favour of a stricken country. It also indicates the existence of a duty to accept offers of humanitarian assistance which meet the requirements mentioned. Two requirements mentioned in Article 70 are that the civilian population must be inadequately supplied, and that relief actions must be humanitarian and impartial and conducted without any adverse distinction. The most important qualification, however, is that relief actions are "subject to the agreement of the Parties concerned" (Art. 70 (1)). Such agreement, if granted, as it should be, may nevertheless have conditions attached.

With regard to non-international conflicts, Common Article 3 of the Geneva Conventions provides that an impartial humanitarian body may offer its services to the Parties. The International Committee of the Red Cross is mentioned as an example of such a body. Additional Protocol II of 1977 added that relief actions for the civilian population "shall be undertaken subject to the consent of the High Contracting Party concerned" (Art. 18). As is well known, this formulation has given rise to controversy and to difficulties of access in situations where assistance can be most urgently needed. Moreover, in some cases the applicability of Common Article 3 or of Protocol II may simply be denied by the Party concerned. In other cases, notwithstanding a need for humanitarian assistance, the degree of violence in a given situation may be insufficient to enable the international humanitarian law of armed conflict to be invoked. Such cases again exemplify weaknesses in the existing law.

The relevant provisions of the Geneva Conventions and Additional Protocols emphasize the humanitarian and impartial nature of relief actions, and of relief societies. The relief societies or agents of humanitarian assistance encountered in the field are very diverse in character, covering a wide spectrum of humanitarian action. For example, relief operations may involve military personnel and military services, national civil defence organizations, National Red Cross or Red Crescent Societies, other authorized relief societies, the International Committee of the Red Cross, the League of Red Cross and Red Crescent Societies, intergovernmental organizations such as agencies of the United Nations, as well as national and international non-governmental organizations or voluntary agencies, either based in the country concerned or coming from abroad, not to mention the spontaneous efforts of private persons.

This list of agents of national or international assistance serves to illustrate the great variety of contemporary humanitarian responses, not all of which are taken into account fully in the Geneva Conventions and Additional Protocols, and not all to an equal extent. In some cases, admittedly, operational organizations are not constituted for exclusively humanitarian purposes, or their activities may not reflect exclusively humanitarian principles. In addition, competition in humanitarian matters is a fact that may aggravate the problems of assistance in situations where difficulties and obstacles to effective action already abound.

## **5. Humanitarian assistance: at the frontiers of international law**

In the light of the above considerations, it is clear that those parts of the international law of armed conflict which deal with humanitarian assistance for civilians are relatively weak in contemporary circumstances. Moreover, as with other parts of the law, application of the relevant provisions will involve interpretation of the legal texts, usually under difficult field conditions. The national or local authority concerned will always seek to apply its own interpretation, which may be narrow and restrictive. If the Parties so intend, they can even adhere to the letter of the law in order to evade compliance with its spirit.

In comparison with the periods when the existing legal instruments were adopted, in 1949 and 1977, circumstances today are both more acute and more complex. There are now many more private or non-governmental organizations involved in humanitarian activities. Non-governmental organizations work in all types of situations, and their actions form an essential part of the global humanitarian system. Resources provided by governments are sometimes channelled through such organizations in considerable quantity. At times, governments providing humanitarian assistance may even find it expedient to remain in the background, as quasi-anonymous “donors”, leaving all operations conducted inside an affected region to their intermediaries. In other situations, States are willing to adopt a much more prominent role, and may even consider undertaking collective measures for humanitarian purposes.

It would thus be hard to deny that three related factors — consent to humanitarian assistance, access to victims, and control over both the operations and the agencies involved — are of central importance in law and in practice. Although authorities can exercise legal or factual discretion to apply controls to humanitarian operations, or even to withhold consent to them, the range of provisions relating to such operations and already embodied in international humanitarian law indicates a clear general development. The overall purport in the Geneva Conventions and their Additional Protocols is that, if at all possible, humanitarian organizations should be given access to areas of need and to victims of conflict who require assistance. But there is a wide gulf between “should” and “must”. Although the law may not necessarily seek compulsion, further attention and progressive development could clearly be usefully concentrated on these important areas.

When they have no other means of survival, people will flee *en masse* to places where they hope to obtain the necessities of life. The destructiveness of war and the weaknesses of existing law have contributed to the recent phenomenon of humanitarian agencies establishing relief centres just outside an affected country. A neighbouring State may well provide a more suitable location for humanitarian assistance operations, including treatment of the sick and wounded, reception of displaced persons, and distribution of food and medicines. Such “external” assistance is significant, since it provides greater opportunities for the conduct of humanitarian operations, though in some cases it may result in new problems, including the unwanted influx of additional refugees. The necessity for this type of response appears to be a direct result of the inadequacies in the present legal context of humanitarian action.

The subject of humanitarian assistance can hardly be adequately discussed without raising the important aspect of coordination of operations, an aspect which is relevant in both war and peace. However, from the strictly legal point of view there is not much to add: the law has not yet been developed in this area, although there is general agreement that coordination can improve the effectiveness of humanitarian action. In practice, a variety of approaches is found among the agencies and at the different levels involved. Defining and achieving appropriate coordination mechanisms has not proved easy. In principle, every person and organization seems to be in favour of coordination, but in practice problems arise in determining who shall coordinate and who shall be coordinated. So far, the main responses in this area are of a political, institutional or administrative nature rather than of a legal character.

As already indicated, the need for humanitarian action in favour of civilians arises not only during conflict, but also in peacetime. In the immediate aftermath of a conflict, in the period of transition to peace, and in the phase of reconstruction there is a compelling need to start or to continue humanitarian assistance operations, and yet there is also the weakest legal foundation for such actions. The needs, the practice and the law are most at variance in this zone. The needs of the victims are at their greatest; the practice of assistance is at its most difficult in view of the disruption of normal relations; and the law that has been considered above, if it is applicable at all, has only a minimum to offer in terms of concrete measures that could contribute to the central aspects of assistance operations. Often most serious, extending across the boundary between war and peace, are the problems of humanitarian assistance for refugees and displaced persons, especially in cases of massive exodus. Moreover, humanitarian assistance is urgently required in various other types of disasters in peacetime, unconnected with armed conflict.

## **6. Draft texts and expert studies**

The pursuit of the above considerations has led discussion to the point where existing legal texts are left behind and possible future developments come into view. It is therefore appropriate to examine briefly some of the different proposals and studies made in recent years with the aim of developing legal instruments or policy relating to humanitarian assistance in general. In the Annex to this article, the principal texts referred to below are listed chronologically, with an indication of the original source for further reference.

One of the first matters raised in this context, and examined within the United Nations, related to the legal status of special relief units. The questions of status, jurisdiction and legal liability which may arise whenever personnel or units undertake humanitarian assistance activities outside their own country, or are made available by international organizations, were raised in the United Nations General Assembly in 1965. Proposals relating to the legal status of relief units covered three situations in which such units might operate: first, as a unit entirely within the United Nations system; second, as a national unit placed at the disposal of the country in need, with the United Nations as a party to the arrangements; and third, as a national unit operating independently under a bilateral agreement. It was suggested that a long-term objective might be to regulate this matter by an international agree-

ment or agreements<sup>4</sup>. The preparation of guidelines for such agreements was given consideration within the United Nations. However, despite general consensus on the need to facilitate humanitarian assistance operations, the differing views of potential donor and recipient States as well as widely varying field conditions have hindered the further development or use of such guideline agreements.

The International Law Association (ILA), a non-governmental organization composed of legal scholars from all over the world, proposed a model agreement on the status of relief units. The ILA started to study legal problems of disaster relief operations in the early 1970s and concentrated on formulating a draft model agreement intended to regulate some of the problematic aspects of international humanitarian action, based on agreements which had actually been used in assistance operations. The final version of the ILA's model agreement was presented in 1980. It emphasized technical matters which can be of importance during a humanitarian assistance operation. Within the context of the model agreement, such an operation was seen exclusively as one which has been requested or accepted by the receiving State.

The next proposal is best referred to as "Measures to expedite international relief", the title used by its promoters. In the resolution which established the Office of the United Nations Disaster Relief Co-ordinator (UNDRO) in 1971, the United Nations General Assembly invited potential recipient governments to consider appropriate legislative or other measures to facilitate the receipt of assistance<sup>5</sup>. The resolution referred to some issues which could contribute to more effective relief operations, emphasizing the problems of overflight and landing rights, and necessary privileges and immunities for relief units. A study of this matter, started jointly by UNDRO and the League of Red Cross and Red Crescent Societies, concentrated on identifying obstacles to the delivery of emergency relief supplies to consignees within disaster-stricken countries. A small step towards overcoming such obstacles was taken in 1976, when the Customs Co-operation Council adopted an instrument on customs procedures relating to urgent consignments. In 1977 a final report was produced, containing recommendations which concentrated on facilitating the functioning of relief personnel and the delivery of relief consignments. In the same year, the United Nations Economic and Social Council, the International

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<sup>4</sup> See United Nations Doc. E/4994, Annex III, 13 May 1971.

<sup>5</sup> See United Nations General Assembly Resolution 2816 (XXVI), para. 8 (e).

Conference of the Red Cross and the United Nations General Assembly all reaffirmed the measures to expedite international relief. Although the expected measures granting the necessary facilities and immunities and taking other relevant action did not materialize, more recent studies have reverted to the original proposals.

The work was carried forward in a study published in 1982 by the United Nations Institute for Training and Research (UNITAR) entitled *Model Rules for Disaster Relief Operations*. The stated purpose of the model rules was “to contribute to closing the lacunae in international humanitarian law regarding assistance to victims of disasters” and “to overcome some of the legal restrictions and bureaucratic impediments which are often major obstacles to the success of a relief operation”. Seventeen model rules for bilateral agreements were formulated. The scope of application of the proposed rules extended to natural and man-made disasters. However, no definition of the term “disaster” was considered necessary by the authors of the study, because the proposed rules were designed to be brought into effect only on the basis of an agreement between the parties in particular circumstances.

The Office of the United Nations Disaster Relief Co-ordinator continued to consider possible legal measures which could help to improve the provision of disaster relief. A report presented to UNDRO in 1983 concentrated on technical impediments to the delivery of relief supplies and included a proposed draft convention for expediting emergency assistance. The draft convention was then considered by a group of experts who made further recommendations with a view to enabling the proposals to gain wider acceptance. Again, however, no further developments took place. Not all organizations involved or potentially involved were in favour of such an approach. A draft convention to facilitate assistance was also presented during the same period within the Organization of American States, but it encountered resistance among the members and was shelved.

The International Atomic Energy Agency (IAEA) attempted to formulate an instrument designed to facilitate emergency assistance in the event of radiation accidents. Guidelines for mutual arrangements were adopted in 1983. Conventions on assistance in the event of a radiological emergency and on early notification of a nuclear accident were introduced in 1986 under the auspices of the IAEA following the Chernobyl disaster. The relatively rapid response of the IAEA member States in this special case is of interest, and the legal obligations contained in these very specific conventions deserve to be closely scrutinized. However, it remains uncertain to what extent the 1986 convention on assistance in a radiological emergency can offer a

model for a general field where humanitarian operations are needed in different circumstances, and are conducted with regularity by a great variety of organizations and other agents.

Promotion of a new international humanitarian order, emphasizing that humanitarian issues remain relatively neglected in international relations, was a more recent proposal brought before the United Nations General Assembly. The expressed objective of the proposal was a comprehensive approach to humanitarian problems, and the closing of the existing gaps in basic humanitarian instruments and mechanisms for humanitarian action. One suggestion in the original proposal relevant to the present subject was a universal declaration of humanitarian principles, which would support the development of humanitarian law beyond the area of armed conflict. The work is currently being pursued by the *Independent Bureau for Humanitarian Issues*, and the topic remains on the agenda of the United Nations General Assembly.<sup>6</sup>

Other proposals and initiatives, in published reports or studies with particular objectives, have discussed the subject of relief operations and even advocated the adoption of various types of instruments relating to humanitarian assistance. Separate proposals relate to minimum humanitarian standards, concentrating on a wider range of civil and political rights but without ignoring the aspect of humanitarian actions. This is not the place to discuss these proposals in detail. Nor is it possible to mention all the relevant internal resolutions and other texts of many of the organizations involved, such as the 1969 Red Cross Declaration of Principles for International Humanitarian Relief to the Civilian Population in Disaster Situations, or the Principles and Rules for Red Cross Disaster Relief. Such texts are obviously closely related to the present subject.

Experience with all the various existing texts, and examination of new proposals and studies make it clear that extending the legal foundations for humanitarian assistance in the situations of greatest need constitutes a major challenge. If this task is to be made an objective of contemporary international humanitarian policy, it would be reasonable to suggest that lessons should first be drawn from the results of previous work tending in the same direction.

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<sup>6</sup> See United Nations General Assembly resolution 45/101 of 14 December 1990.

## 7. Conclusions

While it may be true to assert that the present international regulation of humanitarian efforts could be improved, the exact nature of the legal responses that should follow is not yet apparent. Various attempts have been made to regulate international humanitarian assistance activities in general, and internal regulations already direct the activities of particular organizations and could supply guidance for wider solutions. Yet there is still no international normative instrument which deals comprehensively with humanitarian action, which has gained general acceptance, and which can be applied globally. Such an instrument could in theory take the form of a convention, a declaration, a series of bilateral agreements based on a common pattern, or simply a set of working guidelines accepted by the principal agents involved. It may even be appropriate to think not only or primarily in terms of global responses, but to concentrate on developing more effective regional solutions applicable in the geographical areas of greatest need.

Whatever approach may prove the most suitable, the problem of legal measures relating to international humanitarian assistance is likely to arise at several different levels. One important level is that of technical arrangements to expedite assistance: the concern here is to facilitate the efficient delivery of relief consignments, the movement and functioning of relief personnel, and the provision of adequate communications. Another level of legal interest relates to more fundamental aspects, to the underlying principles of humanitarian assistance: here it seems necessary to consider the framework for initiation and control of assistance operations, and adherence to recognized humanitarian standards during such operations. A related and more ambitious objective might cover a range of humanitarian issues broader than international assistance alone; the results could be reflected in a comprehensive charter or universal declaration of general humanitarian principles. Such a charter or declaration could remedy the lack of guidance in the United Nations Charter with regard to humanitarian matters. The chosen instrument or instruments would also have to clearly approach the questions of a right or duty to provide and a right or duty to receive humanitarian assistance.

Practical measures designed to expedite humanitarian activities, including the appropriate institutional arrangements, remain an important area for further development. Such measures should be based on relevant fundamental principles, with legal and purely institutional responses regarded as complementary. However, the humanitarian field



is very wide, and assistance is required in many different situations. From a global perspective, the greatest needs for humanitarian assistance exist within the context of poverty and underdevelopment. Assistance for refugees and displaced persons should also be taken into account; here again, there is a close relationship with development issues and human rights. The need for humanitarian assistance is in many cases a symptom of other underlying problems, including political and security aspects, either within States or between States. In such a wide field of action, two main approaches therefore appear feasible: either the overall scope of any draft text should be carefully defined and restricted, which would be a difficult supplementary task in itself; or the proposed instrument must be globally conceived and left open to interpretation according to need. Neither of these results may be easy to achieve while incorporating provisions of reasonable practical effectiveness.

The problems of initiation, acceptance and control of humanitarian assistance operations must be faced by those who draft any proposed new instrument or conceive any new institutional arrangements. States able to provide assistance do not necessarily believe that they are under a legal duty to do so, and States needing assistance do not always agree that they must accept such operations. In addition, special problems arise in the context of humanitarian assistance provided to a *de facto* regime, or to persons in need in an area of territory temporarily outside effective governmental control. In general, a receiving State must consent to receive assistance, and an assisting State or organization must be willing to provide it. These are still the two main conditions for humanitarian operations, and the approach to them will largely determine the character of any draft text or new arrangements.

Several special difficulties and recurring problems also have to be faced. One example is the question of transit through third countries: detailed regulation of this matter has often seemed best left to specific agreements concluded between the parties concerned, but this can have the disadvantage of creating partial or fragmentary rules on the subject. The same applies to privileges, immunities and facilities, which are controversial matters likewise sometimes regarded as best governed by specific agreements. The old and recurring problems of coordination and leadership of humanitarian assistance operations remain unresolved in legal and institutional terms, even if a political consensus on the nature of major international operations shows signs of emerging in the aftermath of recent events.

A further consideration is the difficulty of providing satisfactory definitions of even the most common terms employed in the humanitarian sphere, including a definition of the concept "humanitarian" itself, which in practice may be stretched beyond all recognition. The best approach seems to be to avoid any attempt to formulate definitions that prove too difficult. In any case, no definition can by itself eliminate the political component present in so many humanitarian matters.

If humanitarian assistance is provided only with the consent of all the Parties concerned, then no explicit definition of the scope of any proposed instrument or arrangements would be necessary. It is thus reasonable to consider whether any proposed text or the corresponding institutional arrangements should deal preferentially with what might be called mainstream cases, where humanitarian assistance is required and is in fact provided with the willing consent of all concerned. This avenue could lead quite logically to the consolidation and perhaps even "codification" of accepted current practices of a largely technical nature.

On the other hand, a new legal text or revised institutional arrangements could attempt to deal systematically with the more controversial matters and with really difficult cases, such as those arising during and on the periphery of internal conflicts. Such an approach should respond more closely to the specially pressing needs now regularly arising, and might ultimately bring about more far-reaching "progressive development" of the law.

It is not easy to say which of the two approaches may be the more appropriate at present, and indeed they should not be regarded as mutually exclusive; in fact a combined approach may be more realistic. However, the choices involved illustrate a dilemma in establishing priorities. In both cases it will be much more difficult to achieve adoption of a new instrument in a binding legal form rather than in a non-binding form. All these considerations, together with the general factor of reciprocity of obligations, which may require attention, appear particularly relevant to any new efforts to deal with the numerous situations in which the application of humanitarian principles is desirable.

Many suggestions and even some concrete attempts have been made to improve the applicable law. Is this a sign that there is a gradual movement in the direction of further codification or progressive development? Or does the lack of success of past initiatives demonstrate that little progress is possible at the moment? Despite the great needs, all the elements of realism have clearly not yet been

found. Quite simply, the much closer alignment of interests that is a condition for genuine progress has not yet taken place. A promising indication, however, is the appearance on high-level agendas of reforms concerning humanitarian issues. It might be timely, therefore, to analyse even more closely how the separate interests of the victims, of assistance agencies and institutions, and of the States and their authorities sometimes diverge so greatly that, as all too frequently seen, they impede urgently needed humanitarian actions in favour of the civilian population.

The important common feature of most of the relevant draft texts so far produced is the fact that they concentrate on what may be called a humanitarian kernel, set within the whole complex of problems relating more generally to human rights and human dignity, not only in war but also in peace. Most of the drafts deal primarily with the central aspects of humanitarian assistance, in essence suggesting that it may be possible to obtain assistance, and to transport it to the area of need and distribute it to the suffering and needy, on the basis of fundamental humanitarian principles. Despite the evident difficulties in achieving further progress this minimum humanitarian position may at least have some chance of being strengthened and developed, complementary to the existing instruments and approaches. Indeed, as a final thought, if humanitarian matters become a subject of greater international concern, this could in turn have obvious beneficial repercussions in other areas of policy.

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## Annex

### INTERNATIONAL HUMANITARIAN ASSISTANCE

*Selected instruments, draft texts,  
proposals and expert studies  
(since 1976)*

1. Annex concerning urgent consignments (Annex F.5 to the *International Convention on the simplification and harmonization of Customs procedures*, Kyoto, 18 May 1973), approved in Brussels on 18 June 1976; relevant provisions reproduced in United Nations Doc. A/32/64 (1977), Annex II.
2. *ASEAN Declaration for Mutual Assistance on Natural Disasters*, 26 June 1976 (Declaration of the foreign ministers of Indonesia, Malaysia, Philippines, Singapore and Thailand: Association of South-East Asian Nations).
3. "Measures to expedite international relief": XXIIIrd *International Conference of the Red Cross*, Resolution VI; *Office of the United Nations Disaster Relief Co-ordinator*, Report of the Secretary-General, United Nations Doc. A/32/64, Annex II, pp. 1-7, 12 May 1977; *United Nations Economic and Social Council* resolution 2102 (LXIII), 3 August 1977; *United Nations General Assembly* resolution 32/56, 8 December 1977.
4. Resolution 102 (1978) on "Powers and responsibilities of local and regional authorities regarding civil protection and mutual aid in the event of disasters occurring in frontier regions", with appendix of two model agreements, *Conference of Local and Regional Authorities of Europe*, 22 June 1978.
5. "Draft model agreement relating to humanitarian relief actions", *International Law Association*, Report of the Fifty-Ninth Conference, Belgrade, 17-23 August 1980 (ILA: 1982), pp. 512-527.
6. "New international humanitarian order" — Jordan: request for the inclusion of an additional item in the agenda of the thirty-sixth session. *United Nations* Doc. A/36/245, 30 October 1981.
7. M. El. Baradei *et al.*, "Model rules for disaster relief operations", *United Nations Institute for Training and Research*, Policy and Efficacy Studies No. 8 (UNITAR: 1982), UN Sales No. E.82.XV.PE/8.
8. "Draft Convention on expediting the delivery of emergency assistance", *United Nations General Assembly and Economic and Social Council*, *Office of the United Nations Disaster Relief Co-ordinator*, Report of the Secretary-General, United Nations Doc. A/39/267/Add.2 — E/1984/96/Add.2, pp. 5-18, 18 June 1984.

9. "Draft Inter-American Convention to facilitate assistance in cases of disaster", Recommendations and Reports of the *Inter-American Juridical Committee, Organization of American States*, Official Documents (OAS, Secretariat for Legal Affairs: 1985), Vol. XVI (1984), pp. 34-38.
  10. Resolution of the *International Academy of Human Rights*, Copenhagen Symposium on the "Right to Humanitarian Assistance in the Perspective of the Chernobyl Accident", 31 August 1986.
  11. "Convention on Assistance in the Case of a Nuclear Accident or Radiological Emergency," Vienna, 26 September 1986, *International Atomic Energy Agency*, Doc. GC (SPL. I)/Resolutions (1986).
  12. Resolution on the "Recognition of the duty to provide humanitarian assistance and the right to this assistance", *Conference on Humanitarian Law and Morals*, Paris, 26-28 January 1987.
  13. "Draft International Guidelines for Humanitarian Assistance Operations", *Humanitäres Völkerrecht, Informationsschriften*, German Red Cross, Bonn, Vol. 3, 1990, pp. 143-146.
  14. "Draft Declaration of Minimum Humanitarian Standards", adopted in Turku/Åbo on 2 December 1990, *American Journal of International Law*, Vol. 85, 1991, pp. 375-381.
  15. "Humanitarian assistance to victims of natural disasters and similar emergency situations", *United Nations General Assembly* resolution 45/100, 14 December 1990. See also the Report of the Secretary-General, Doc. A/45/587 (1990).
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# Health protection in armed conflicts

by Dr. Rémi Russbach

## 1. Introduction

Armed conflicts always have dire effects on the health of the civilian population. Apart from the harm — wounds, burns, asphyxia and radiation — caused directly by weapons of war, the people fall prey to disease because of the disruption of their normal living conditions.

In most cases, it is the latter rather than the former which takes the greatest toll.

Some basic health protection principles are therefore common to all development and disaster situations.

These are to be found first and foremost in the relationship between a group of individuals and the environment in which they are living, as it is this environment that will determine the type of risks and problems the community will have to face.

Hence a knowledge of the area and its inhabitants is essential in determining priority measures to protect the health of the greatest number of people.

This strategy has proved its worth; it goes beyond individual medical care in that its preventive effect affords long-term protection to the community as a whole.

Cleaning up the environment, protecting water sources, controlling disease vectors (insects, rodents, etc.) and developing an agricultural and economic system that gives everyone access to food may be the courses of action that an expert in public health would propose after having studied the health situation of a population at risk.

Although today this community approach is fully appreciated and accepted in most cases, it may be misunderstood by the victims if it is not accompanied by curative activities.

Indeed, the demand for medical care is mainly individual and personal and it has to be explained why the common interest takes precedence.

It may happen that those in charge of dispensing medical aid, with limited resources at their disposal, make poor use of those resources, neglecting the interests of the community in general to concentrate on a few individual cases. This indicates a lack of understanding of the problem and the remedy is improved training of medical aid officials.

In the event of *natural disasters*, the victims are initially going to be subject to physical injury, depending on the nature of the disaster. Floods cause death by drowning, volcanic eruptions result in burns and asphyxia, in earthquakes people are crushed, etc.

However, once this initial phase is over, the people who have to live in the devastated area or are obliged to flee will find themselves in an environment harmful to their health. To protect them, the basic principles outlined above must be taken into consideration and emergency action must be taken.

As is the case for industrial disasters, the time factor and logistics are the main constraints.

Difficulty in gaining access to victims, hostility on the part of the authorities and the politicization of aid, which are the major constraints during conflicts, are not usually serious stumbling-blocks in other situations.

To safeguard the health of the civilian population in an armed conflict, the first step is to identify the main problems and the many constraints that make any kind of assistance difficult in such situations.

## **2. Effects of war on health and on medical services**

When a conflict situation escalates into all-out war, the social and economic balance is suddenly disrupted and priorities and values undergo a fundamental change. Everything is geared towards the war effort; non-participants find themselves without support from the authorities. Those who were already living in precarious circumstances before the events become much more vulnerable and risk losing what they need to remain in relatively good health, or even to survive.

Certain ethnic or political groups become suspect in the eyes of the authorities, which will not only deprive them of the protection to which they are entitled but also consider them as potential enemies. They then risk being persecuted without having any possibility of finding protection elsewhere.

In situations of internal armed conflict, the civilian population is often caught in a trap. Families whose only aspiration is to live a quiet life find themselves forced to abandon their land after having been held to ransom by one party and accused of collaboration by the other. As a result they lose their livelihood and their health suffers accordingly.

The population movements prompted by such a complex and hopeless state of affairs themselves represent a major threat to health, since they are always accompanied by serious damage to the environment in which essentially vulnerable people are living.

When war is raging and health problems directly related to the situation get out of hand, the crisis is compounded by wounds caused by bullets, fragments, mines and all other kinds of deadly devices. The medical services, generally disorganized and partly destroyed, are then overwhelmed by the number of wounded and sick.

For in wartime, when the health services should be able to cope with many more patients, they are often themselves on the point of collapse. When hospitals are damaged or destroyed, fewer beds are available. Power cuts bring hospital services to a halt (lighting, ventilation, lifts, sterilizers, etc.). Water shortages seriously disrupt the medical care system and cause insuperable hygiene problems. Furthermore, there may not be enough medicines and medical equipment to provide the most basic treatment.

In such circumstances even the most highly motivated health workers will be disheartened. A stage is reached where conditions become too dangerous, salaries cease to be paid and work is abandoned.

The breakdown of communications and the hazards of travelling prevent patients from reaching health centres and most of them find themselves without any medical care.

All public health programmes, vaccinations, maternal and child health care and campaigns to control major endemic diseases grind to a halt in the same way as the curative services and this in turn leads to an increase in the incidence of disease.

In extreme cases, chaos reigns when all facilities are destroyed and no single authority is in charge; power is split up between small groups that indulge in plunder and arbitrary violence among themselves and against the people.



### 3. What must be done to safeguard health

This is the type of situation in which humanitarian organizations are called upon to work and it is easy to imagine how difficult and frustrating their task can be, for the resources available are quite insignificant in comparison with the vast range of health problems to be tackled.

Whatever the resources mobilized, humanitarian organizations and agencies specializing in health matters must realize that they could never do everything that needs to be done because of the insurmountable obstacles in the way of aid activities. Yet they must endeavour to take pragmatic and sympathetic action to help those who are suffering the tragic effects of war.

As a neutral and independent organization, the ICRC has a very special part to play in health protection during armed conflicts. The mandate conferred upon it by the States party to the Geneva Conventions and their Additional Protocols, its right of initiative and its role as a neutral intermediary enable it to approach health problems from many different angles and to go beyond the traditional forms of medical assistance which other organizations are also in a position to provide.

The ICRC may adopt various approaches to safeguard the health of victims of armed conflicts:

- direct medical action;
- material assistance and moral support;
- negotiation.

In practice, medical activities often involve all three elements.

**Direct medical action** is taken when expatriates have to be brought in, either because there are not enough local staff or because neutral personnel are necessary to gain the confidence of the various parties to the conflict.

These operations are planned on the basis of the most urgent needs observed and various means may be deployed. For example:

- war surgery units;
- dispensary teams;
- teams responsible for nutritional surveys and distributing food aid;
- teams in charge of environmental sanitation or water supply programmes;

— teams in charge of orthopaedic rehabilitation programmes.

In such cases the programmes are set up by expatriate specialists, most of whom are seconded to the ICRC by the National Red Cross and Red Crescent Societies. Locally recruited staff play a considerable part in these activities; indeed, for every expatriate ten people are engaged locally to work in the ICRC's medical projects.

We shall not describe activities of this type in further detail here, as they are dealt with elsewhere in this issue.

***Material assistance and moral support*** have proved their worth and yield spectacular results using a small number of personnel. They involve identifying local resources which might be restored with a minimum of external aid and might improve the health of the population.

Sometimes, by donating vital materials and equipment and providing encouragement, facilities such as hospitals, water-pumping stations or pharmaceutical factories, systems for evacuating the wounded or national public health programmes can be repaired or restored, or at least saved from dereliction.

Here the ICRC acts as a catalyst, by enabling local services to function independently with a modest amount of aid and psychological support which gives new courage to those who had given up hope.

The impact of this kind of work goes far beyond the health sphere. The realization that parts of the infrastructure can be made to work again may lead to other indispensable activities being resumed and constitute the first step towards the country's economic recovery.

***Negotiating*** health protection measures with the authorities is one of the ICRC's more specific tasks, and one which can be of the greatest benefit to the health of vulnerable groups.

ICRC delegates, when conducting negotiations with the authorities about problems concerning prisoners of war, displaced people, or access to conflict zones, raise fundamental issues to which those in power cannot remain indifferent and which, if settled, can have a decisive influence on the destiny of entire populations.

In such discussions, ICRC delegates base their arguments on the Geneva Conventions and their Additional Protocols. The provisions of

these treaties, if respected, afford entirely satisfactory protection for the victims of armed conflicts and especially for their health.<sup>1, 2</sup>

Negotiations of this kind may lead to more effective and lasting measures for protecting community health than direct medical action or material assistance and moral support. Agreements to call a truce, lift a blockade, allow farmers to return to their fields, or guarantee due respect for hospitals and medical personnel can have far-reaching effects at little cost.

In conflict situations ICRC doctors and health personnel are in a unique position. Their professional expertise inspires respect and confidence and they are not involved in the conflict. They constitute an external point of reference which helps those caught up in the hostilities to regain a sense of perspective. This external point of reference, provided by people who have chosen to work in such circumstances, introduces a dimension other than that of force and violence; it generates a collective awareness which in turn can lead to a resurgence of the fundamental, universal humanitarian values that become obscured in the heat of war.

This restoration of humanitarian values can resolve certain situations which are very damaging to health, and give new courage to local health staff demoralized by the events.

*Some examples:*

- A good illustration of this approach was the action taken by the ICRC to reactivate the hospital in Jaffna, **Sri Lanka**. This 1,100-bed hospital could no longer function because it was in a zone battered by the conflict between government troops and Tamil rebel movements.

Since neither patients nor medical personnel could reach the hospital, they had to use a small, private institution which had inadequate facilities to cope with the wounded and sick from the Jaffna region.

By negotiating with the parties concerned, the ICRC succeeded in reaching an agreement whereby free access to the hospital and proper protection were guaranteed for patients and medical staff.

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<sup>1</sup> J. J. Surbeck and R. Russbach, "Le Droit International Humanitaire et la protection de la santé", *Revue Québécoise de Droit international*, Vol. 2, 1985, pp. 155-193.

<sup>2</sup> A. Baccino-Astrada, *Manual on the rights and duties of medical personnel in armed conflicts*, ICRC-League, Geneva, 1982.

At the outset the mere presence of four ICRC medical delegates and nurses gave new confidence to the hospital staff, who even ferried them from their homes to their place of work in vehicles marked with the red cross emblem. The delegates also protected convoys of medical supplies and medicines sent in by the Ministry of Health in Colombo.

After a few days the hospital began to function normally, thanks to four expatriates. Now, with local resources, it can cope with problems which humanitarian organizations would certainly not have had the means to handle on a long-term basis.

- Another example of what can be achieved by negotiation occurred in Santa Cruz, *El Salvador*. An entire region was without safe water because the water supply system had broken down in an area inaccessible to government services.

The ICRC succeeded in gaining assurances that the army would not harass the company repairing the water distribution system. The supply of drinking water was thus restored, with obviously beneficial effects on the health of the region's inhabitants.

- ICRC surgical work in *Afghanistan* furnishes yet another example.

For several months, ICRC medical personnel were able to evacuate the wounded from rebel-held territory to capital, Kabul, where they were treated before being taken back across the front line. This was achieved by means of constant negotiations with the various parties involved.

## 4. Constraints

The numerous constraints inherent in situations of armed conflict make it very difficult to safeguard the health of the population.

Among the most serious is the *difficulty in gaining access* to the victims, because it holds up every phase of the operation, from the initial assessment right up to the end result.

What can be done to gain this direct access, without which no effective help is possible? The problem can only be solved by negotiations with the military and political authorities; provided, however, that they realize they are not losing any military or political advantage by giving outside organizations access to the victims.

The ICRC's neutrality and impartiality, if clearly explained to the authorities, will win their trust and make it easier to reach the victims wherever they are.

The persuasiveness of arguments based on the Geneva Conventions and their Additional Protocols varies enormously depending on the position of the people being approached.

It is generally the least privileged section of the population that is the most difficult to reach. In some situations the social system raises serious obstacles; the ICRC cannot gain access to people at the bottom of the social scale without going through those in power who govern — and even exploit — them.

Thus a thorough knowledge of social structures in the area is necessary to have any chance of success in helping the weakest.

**External constraints** may also seriously hinder efforts to protect health.

For example, an international embargo may hamper the dispatch of certain articles which are essential to health although not classified as medical and pharmaceutical products (e.g., items needed to supply drinking water or energy to medical centres, to transport the wounded and sick, etc.).

Media overreaction to certain situations may also disrupt medical relief work by triggering a disproportionate response on the part of the donors; this too is a kind of constraint that can hamper the smooth running of a programme.

Indeed, the dispatch of excessive amounts of non-essential supplies or large numbers of untrained personnel may stall the entire health protection system, divert efforts from priority activities and generally make the situation worse. Specialists in disaster relief are well aware of this phenomenon, which could be avoided by educating the public and the media to react in a reasonable and controlled manner to emergency situations.

Lack of financial, material and human resources also represents a considerable constraint, especially when armed conflict breaks out in an impoverished area.

## 5. Conclusions

Health protection during armed conflicts is a priority, because war always leads to a deterioration in living conditions and upsets the social and economic balance. Both these phenomena have grave effects on health: armed conflicts can plunge entire populations into poverty and disease and, for the most vulnerable, death is often inevitable.

If they were respected at all times by belligerents, the Geneva Conventions and their Additional Protocols could go a very long way towards protecting health.

An effort must therefore be made to ensure that existing law is applied more effectively before planning new conventions.

Outside aid must be based on a permanent assessment of needs, and the means deployed must be tailored to the priorities observed in order to make optimum use of the resources available.

Health protection is everyone's responsibility and local communities must play a part, with the support of outside organizations at various levels.

The different courses of action must complement each other. Since external resources in terms of qualified personnel and equipment are limited, efforts should focus on developing the role of "catalyst", which encourages local activities, and of negotiator, which can help victims gain access to vital resources.

In our view, the future of health protection for victims of armed conflict lies in this type of activities.

**Dr. Rémi Russbach**

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Dr. Russbach was appointed Chief Medical Officer of the ICRC and Head of the Medical Division, which he founded, in 1977. In 1986 he set up the training course entitled Health Emergencies in Large Populations (HELP). He has been Vice-President of the International Society for Disaster Medicine (ISDM) since 1987.

# The role of the doctor in ICRC visits to prisoners

by Dr. Hernán Reyes  
and Dr. Rémi Russbach

## 1. Introduction

The ICRC visits prisoners all over the world, whether they are prisoners of war in camps or political detainees held in prisons or police stations. In 1990, ICRC delegates visited more than 84,000 prisoners in about 40 countries.<sup>1</sup> These visits are made by teams of delegates, the number of whom varies depending on the number of prisoners to be seen. Each team is made up of Swiss delegates specially trained to carry out such visits, including at least one doctor.

Doctors who become medical delegates are therefore delegates of the ICRC in the fullest sense. They must have had a minimum of three years' clinical experience and undertake an initial engagement of one year. Before they join a delegation they receive specific training on the activities of the ICRC and on the work done by delegates in places of detention. Once they have been trained and acquired some experience, medical delegates may be engaged for missions of shorter duration.

The ICRC doctor has two distinct roles within the team of delegates making visits:

- He is responsible for *assessing the state of health* of the prisoners, also every aspect of life in detention that impinges on health (food, hygiene, medical care, etc.). This role is that of an expert adviser, not of a doctor providing treatment.

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<sup>1</sup> There may be two or more contexts to a conflict in one and the same country: in Afghanistan, for example, the ICRC visits prisoners in the hands of the government authorities in Kabul and elsewhere; ICRC delegates also visit those held by the Mujaheddin, on Afghan soil, but do so from a delegation based in Pakistan.

- Where there are *allegations of ill-treatment*, the doctor is responsible for obtaining the medical data required to establish a file on the subject, so that the ICRC can call on the competent authorities to put an end to such practices. As a medical adviser from outside, the ICRC doctor also has a role to play among the victims themselves, who can trust him.

## **2. Assessment of prisoners' state of health**

The assessment made by the ICRC doctor covers the prisoners' state of health and the various systems existing within the place of detention to ensure their survival: food, hygiene, medical care, etc. He (or she) must therefore examine the various aspects of life in captivity. In order to obtain all the information he needs, he talks not only with the prisoners but also with the medical staff in the place of detention.

If nutrition is unsatisfactory, the ICRC doctor takes care to make a representative selection of prisoners. He must note objective signs of malnutrition, such as loss of weight, symptoms of deficiencies and lack of vitamins (beriberi, pellagra, xerophthalmia, scurvy, etc.), any or all of which provide proof that the diet is not adequate. However, the absence of any such signs does not mean that the rations supplied by the authorities are sufficient, since prisoners' relatives might be bringing food that compensates for the inadequacy of the official rations.

The ICRC doctor must make a detailed analysis of the food provided to prisoners, in order to determine whether there are deficiencies. This implies not only analysing the meals supplied on the day of the visit but also examining other non-medical features, such as the budget for purchasing food, the way in which foodstuffs are stored, whether or not prisoners' relatives bring them food, etc. These various factors, plus the doctor's professional medical report, enable the team to have an overall view of the situation. In no case, except in life-threatening conditions, does the ICRC take the place of the authorities in providing food to the prisoners; but it does attempt to discover the cause of the inadequacy (insufficient funds, food being diverted for consumption elsewhere, incompetence, etc.), in order to propose a solution and thus help the authorities to meet their responsibilities.



If sanitation<sup>2</sup> in the widest sense is unsatisfactory, with adverse effects on the health of those in detention, it is the ICRC doctor who, after he has made his assessment, must decide what measures are necessary. If need be, he will call on the help of specialists in water supplies and environmental sanitation.

Sanitation is a very extensive subject, covering the study of such matters as:

- *water supplies*, in sufficient quantity and quality for the prisoners, as a vital necessity for health;
- *elimination of waste water and solid wastes*, to avoid the possibility of contamination, disease and even epidemics;
- *vectors* (ectoparasites, rodents, insects, etc.), the presence of which can cause the spread of various diseases (malaria, bubonic plague, rickettsiosis, etc.);
- *general living conditions* in the place of detention, density of occupation of quarters, ventilation, cleanliness (the influence of the latter on health goes without saying).

The *medical system* for providing health care to the prisoners within the place of detention is also studied by the ICRC doctor, with special attention to its actual functioning. This means that he inspects the installations (infirmary/sick bay, consulting room, etc.) and talks with the medical staff, whose opinions and, at times, grievances are very useful for understanding how the system works and why it may break down (minimal pay of medical staff resulting in absenteeism, insufficient funds made available for medicines, system sabotaged by the prisoners, lack of transport for taking patients to hospital, feeling of insecurity among care staff, etc.).

The ICRC doctor also listens to the prisoners' account of the medical facilities. He hears some of them in private, away from the influence of the authorities, naturally, but also away from that of their group, which, among political prisoners especially, may impair the objectivity of the information.

The ICRC doctor always makes a point of examining a representative sample of prisoners to obtain an objective idea both of their state of health and of the quality of the medical treatment provided by the detaining authorities.

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<sup>2</sup> Term that includes all matters connected with water supplies, sanitary engineering (drainage, sewerage, etc.) and hygiene.

***The ICRC doctor takes care not to act as a substitute for the existing system but to make it function as it should.***

The means used to achieve this aim will, of course, vary according to circumstances. Persuasion through dialogue with the local doctors may be all that is needed to settle some problems. In other cases, the ICRC will give aid in the form of medical supplies to a prison doctor who has none. In exceptional cases, the ICRC may request the release of prisoners who are seriously ill or badly wounded if it considers that this would be of benefit to them.

In assessing the various systems and the prisoners' general state of health, the purpose of the ICRC doctor is to obtain an objective view of the shortcomings and to identify the reasons for them. The ICRC, as an institution, is then able to put forward specific and practicable proposals for improvements to be made by the detaining authorities.

It does so through specific steps taken by the delegation and by giving the higher authorities an official written report on the visit. A problem that has been described in a report by the ICRC can no longer be ignored by the authorities, and the ICRC's proposals may start a process of improvement. The prospect of another visit by ICRC delegates in the fairly near future is a major factor in furthering this process.

### **3. Role of the ICRC doctor in the event of ill-treatment<sup>3</sup>**

If the prisoners tell the delegates that they have been ill treated, the ICRC does its best to ascertain the facts and draw up a complete file, in order to notify the responsible authorities and ask them to terminate such practices. In such circumstances, the ICRC doctor has to examine the detainees and give a professional opinion on their state of health and on the possible relationship between any lesions he may find and the allegations made.

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<sup>3</sup> The term "ill-treatment" is the one currently used in the official documents of the ICRC. It refers in fact to cases of torture and of cruel, inhuman or degrading treatment, as defined or cited in various international conventions against torture. The use of the term is not due to prudery or timidity: it enables the ICRC to report on these matters without the risk of automatic rejection by the authorities (for example, if the word "torture" were used). The subsequent description of the facts leaves no doubt as to what is meant (*see below*).

The doctor examines each case individually and also attempts to discern ill-treatment as a collective phenomenon that must be understood and discussed with the authorities in its entirety. The two approaches, individual and general, are impossible to separate.

The ICRC doctor must also inform, reassure and advise the victims of ill-treatment, since he is a “neutral doctor”, sometimes the only doctor whom the victims trust. Very often he is able to relieve their minds simply by explaining the after-effects of torture and the possibilities of therapy available once the prisoners have been released.

#### **(a) How the ICRC combats torture worldwide**

The ICRC itself has not adopted any definition of torture. Its role is not to prove the existence of torture before a tribunal, but to take action to help victims so that torture is stopped. When the ICRC receives allegations of treatment that it considers equivalent to torture or to the category of treatment defined by the UN as cruel, inhuman or degrading, it compiles a special file that is submitted in confidence to the detaining authorities. The form of the file depends on the circumstances, the number of cases and the seriousness of the facts. Yet in every case the action taken is the same: *the ICRC calls on the authorities to take all necessary measures immediately to put a stop to such practices.*

Although the ICRC does not have its own definition of torture, its doctors refer to definitions that are universally accepted, such as:

- the definition adopted by the World Medical Association (WMA) in the “Tokyo Declaration” of 1975; and
- the definition contained in the 1984 UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment.

None of the existing definitions of torture gives details of the “grey area” represented by cruel, inhuman or degrading treatment. This raises questions particularly regarding conditions of detention. What degree of overcrowding constitutes degrading treatment? What is to be said of latrines shared by hundreds of prisoners in poor conditions of hygiene? Is the body-searching of detainees degrading? The ICRC doctors are able to refer to certain texts;

- the UN Standard Minimum Rules for the Treatment of Prisoners (1984);

- the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1989).

For the ICRC the Minimum Rules serve as a guideline, but not as an absolute criterion. Depending on the circumstances and the possibilities of the detaining country, the ICRC may demand more than the strict minimum set down in the Rules.

## **(b) Interviews with prisoners**

The interview in private (“without witnesses”) between the ICRC doctor and the prisoner is the most important phase in this type of visit. During the interview, the doctor will, obviously, avoid anything that might seem like another “interrogation”. Here, tact at the outset, and a sympathetic hearing are the essential requirements.

In questioning the victim about the ill-treatment he has received, the ICRC doctor must bear in mind that he is entering into a very personal sphere. This intrusion into a recent experience that the prisoner has tried — usually in vain — to forget may be traumatic. Some prisoners take the opportunity to “tell it all”, since they need to talk about their experience. The fact that they can talk to someone other than their fellow detainees may be beneficial in itself. Other victims are unable or unwilling to talk about their ill-treatment. In some cultures, where important matters are never discussed straight out during a first meeting, prisoners will obviously be most reluctant to speak about such an intimate subject.

Non-medical delegates who talk with these prisoners must take the utmost care not to invade their privacy. It is better to interrupt an interview than to cause distress. Here the other delegates can turn to the doctor in the team, who is, by training and by experience, more accustomed to this difficult type of interview.

After noting the allegations of ill-treatment, the ICRC doctor examines the prisoner. The examination takes place in private, ideally without an interpreter (provided that the ICRC doctor is fortunate enough to speak the language of the prisoner’s country). If an interpreter is needed, the prisoner himself *chooses* one.

The physical examination has three main aspects:

- First of all, it forms part of the normal relationship between a doctor and a patient. The prisoner moreover expects it, particularly if he has not been seen by the doctor in the place of detention, either for lack of time or because of negligence.

- Secondly, the ICRC doctor must see for himself exactly what physical consequences the torture has had. On the one hand, he must compare existing traces with the allegations made by the prisoner, but above all he must get a clear personal idea of the various methods used to produce visible after-effects (also psychological effects — see below).
- Finally, examination of the victim is essential for the ICRC doctor to provide him with the only immediate service possible: a tentative diagnosis of his condition and an estimate of future progress. Often the doctor is able to add some practical advice (for example, on physiotherapy that the prisoner can give to himself).

**(c) The specific role of the ICRC doctor vis-à-vis victims of torture**

Ideally, the ICRC doctor should examine every prisoner who has been tortured. Since this is impossible when the number of victims is very large, the doctor must choose a representative sample from the group, so as to obtain a general idea of the situation.

There are several reasons why the ICRC doctor ought to try to see every person who has been ill-treated:

- victims will usually discuss their problems more readily with a doctor than with the other ICRC delegates;
- victims need to be reassured as to their state of health;
- only the doctor in the visiting ICRC team is able, because of his expert knowledge, to provide professional evidence for the file on ill-treatment so that the ICRC can take the necessary steps to help the victims;
- the ICRC doctor can have a beneficial influence on prisoners suffering from psychological disorders as a result of ill-treatment, if he says the right thing at the right time;
- if medical staff are alleged to have taken part in torture, it is essential for the ICRC doctor himself to collect all the information so that he can take action.

The above points merit closer consideration.

● ***Victims will discuss their problems more readily with a doctor***

Experience shows that a victim's account of torture differs depending on whether it is given to a "lay" person (i.e., not a doctor)

or to someone from the medical profession. This is particularly true when the torture is of a sexual nature. It should be pointed out that this type of torture is universal. Such treatment is easier to describe to a doctor, since the victim feels less ill at ease as the “patient” speaking to “his/her own doctor” than in a non-medical context. The reluctance to report the torture suffered naturally varies according to the individual’s cultural and ethnic background. The sex of the doctor will play a role in some cultures: for example, a male doctor will not be allowed to talk to or examine women in some Muslim countries. On the other hand, experience has shown that the opposite is not always true (at least for the interview): many male prisoners are very willing to confide in a woman doctor, who thus acts as a sister or a mother.

Sometimes the account of sexual torture is accompanied by an appeal, explicit or tacit, from the victim. In some way the victim wants the doctor to take a professional attitude so that he can pluck up the courage to ask questions. Others prefer the doctor to lead the discussion.

Since torture is an assault on their most intimate selves it is completely understandable that victims should prefer to talk to someone who can reply to questions they cannot or dare not express.

Some want to be told that their injuries are not permanent; others simply need to tell their story to someone without feeling ashamed or embarrassed; many merely wish to be reassured that what they feel is “normal”.

- *The detainee needs to be reassured as to his state of health*

The physical injuries may range from superficial, apparently unimportant, scars to severe or disabling lesions. It is certainly not necessary to be a doctor to realize that circular scars at the base of both thumbs is probably due to the thumbs having been tied tightly with string for a long period, as usually reported by prisoners. Nor is it necessary to be an expert in medical law to know that multiple scars on the back are abnormal and are due, until the contrary is proved, to the whipping alleged by the detainee.

In both cases, however, the victims must be examined by the ICRC doctor. Even if the lesions are minor, there may be associated problems that should receive the doctor’s attention. In the first case described, that of the scarred thumbs, victims often complain of the absence of sensation below the compressed area.

The ICRC doctor must examine the patient's hands to be able to reassure him. Most of the time the effect is temporary anaesthesia due to damage to the sensory nerve, and this will very gradually recover its function as long as the nerve sheath has not been destroyed.

In the second case, the doctor must take note of the lesions and see whether any treatment can be suggested to the patient. After a physical examination, the victim can be informed of his condition and told of the probable future progress of the lesions.

These two cases were chosen because they are relatively frequent occurrences, for which non-medical delegates often think that the doctor's opinion does not appear necessary. Yet experience has shown that victims of such ill-treatment have been reassured simply by having the professional opinion of a "neutral" doctor.

When torture is related directly or indirectly to the reproductive organs, victims very frequently ask questions such as "Will I still be able to have children?" or "Will I be able to have intercourse with my wife?".

Such questions will arise more or less easily, depending on the extent of the cultural barrier between prisoners and delegates. In every case, the ICRC doctor is the one best placed to answer them, as the only person possessing both theoretical and clinical experience.

- ***Only the doctor can provide expert testimony in support of the file on ill-treatment***

Naturally, there are many cases of physical torture where medical expertise is patently justified. Disability due to badly healed fractures (pseudarthrosis, for example), shrunken scars, specific lesions of organs, residual paresis or paralysis, are the most frequent physical after-effects of torture.

In such cases, the doctor's role is to make an objective professional evaluation of the after-effects. Subsequently, the ICRC will take the necessary action, depending on the severity of the cases. It will request, for example, that the victims be hospitalized or given special treatment or that they be provided with prostheses, etc. These moves in favour of individuals supplement the ICRC's more general approaches to the authorities designed to put a stop to the phenomenon of torture.

For a victim disabled by torture, the meeting with an ICRC doctor is the means by which he will perhaps be supplied with a prosthesis or receive suitable medical treatment, and this is what counts most for

him, irrespective of other steps taken by the ICRC, the benefits of which he will see only later and indirectly.

This brings us to the compilation of a professional medical report on torture. The ICRC is not a body that carries out inquiries as such, and it acts only in the direct interests of the victims. This means that it does not seek to “prove”, to provide evidence that torture exists. Nevertheless, it is indispensable for the ICRC to have a well-documented file if it is to be able to take action with the relevant authorities at a later stage. Experience has shown that the description of lesions observed must use precise and recognized terminology. This is particularly true when the authority to whom the file is to be submitted is “sceptical”.

When the ICRC reports allegations of ill-treatment to the authorities, it is vital that the victims’ account be accompanied by a precise and irrefutable description of the lesions noted by the ICRC doctor, a description that will stand up against any contrary medical report produced by the detaining authority. However, the ICRC’s description, though rigorously accurate, must not be esoteric, since it must be comprehensible to a non-medical reader.

A file may take one of a number of forms. It may report on several individual cases, the medical opinion taking the form of a clinical description of each case, with documentation of the lesions noted, the patient’s functional disabilities and their probable cause.

In some cases, the ICRC doctor analyses a series of cases without giving details of individual victims. This applies, for example, when he is documenting types of ill-treatment inflicted on a group of detainees.

The ICRC medical delegates, therefore, though not trained in medical law, must be conversant with the precise and specific terminology applied to torture. They alone, as doctors, are qualified to decide what is “compatible” or not with the detainees’ allegations.

It should not be assumed that the ICRC acts only in cases of torture where there are compatible physical lesions. Very often it takes action when there are no lesions to be seen, either because the torture has left no trace or because the period of time since it took place is long enough for all traces to have disappeared.

- *The ICRC doctor may have a beneficial influence on prisoners suffering from psychological disturbances*

The mental and emotional injuries resulting from torture are often



much worse than the visible lesions. Experts do not yet all agree on what in fact constitutes a “torture syndrome”.

With this type of victim too, the ICRC doctor has a role to play. Obviously, in most cases, torture victims will be suffering from both physical and psychological traumata. The two categories of symptoms are indissociable, and the distinction should in fact be dropped. Every type of “physical” torture has psychological repercussions; similarly, “psychological” torture has physical results on the victims.

A common denominator of all forms of torture appears to be the extreme stress and anxiety it arouses in the victims. A table of “psychological after-effects” has thus been compiled. On the other hand, the physical after-effects of various forms of physical torture differ greatly depending on their nature and intensity.

In the context of psychological after-effects of torture, the role of the ICRC doctor is clearly very difficult. Obviously, in the space of a single visit it is impossible to consider giving “treatment” as such. Nevertheless, by examining each victim separately, he will be able to give the advice most appropriate for that particular person and from time to time even to reassure the victim that his feelings in relation to his psychological sufferings are no more than a normal reaction to extreme psychological assault.

Some victims may be less troubled than others by such phenomena as a false sense of guilt, nightmares, difficulties in concentrating, loss of memory, emotional problems, loss of self-esteem and self-confidence: all these are merely normal reactions to extreme aggression, which is *not* normal. This is something only a doctor outside the system is able to tell them.

- ***If it is alleged that medical staff have taken part in torture, then the ICRC doctor himself must carry out an investigation.***

The participation of doctors in torture is very widespread in the world of today. Recent studies even claim that it is universal, since torturers require “medical advice” to carry out their work.

It is likewise true that persons in white coats sometimes take part in torture sessions, passing themselves off to the victims as doctors, occasionally playing the role of the “good man” in the well-known alternation of “good man” and “bad man”, used as a technique of psychological destabilization.

Whatever the facts of the matter, the part played by medical staff in torture must be substantiated by objective proof. The ICRC doctor must if possible establish the facts exactly and be satisfied that the

persons concerned are really doctors, by asking pertinent questions. Experience shows that it is relatively easy to discover whether someone in a white coat is indeed a doctor or an impostor.

Once the ICRC doctor has made a report on doctors taking part in torture, he may if appropriate refer the case to the local medical association. Conversely, when he is approached by doctors whom the detaining authorities wish to force to take part in torture, it is his duty to take steps to support and protect them.

#### **(d) Physical examination of the patient in the event of torture**

At times, circumstances dictate the ICRC doctor's working conditions. If he has to see 2,000 detainees in five days, it is obvious that he will not be able to examine each of them personally.

Yet he must do his utmost to assign priorities and give the time required to the severest cases, whether solely medical or related to torture.

If circumstances do allow thorough individual examinations, which is most often the case, the doctor proceeds methodically and meticulously.

It is desirable for him to have a diagram of the body, so that his documentation will be comprehensible to other readers. However, such a diagram is never a substitute for a description of lesions, using a precise vocabulary. The diagram is chiefly useful for noting and siting the lesions, which are then easy to find later. The way in which the doctor makes his examination is not important as long as it is logical. The following systematic approach is given as an example:

- classification of lesions by anatomical area (e.g., head and neck; face; thorax; shoulders; back (upper and lower); abdomen; legs (left and right, distinguishing the three levels of thigh, knee and lower leg); arms (*ditto*); hands; feet; sexual organs).

Under each area, the lesions noted must be classified in accordance with a number of criteria:

- age of lesions
- type of lesion (abrasion, cut, laceration, contusion, burn, etc.)
- additional lesions noted (e.g., atrophy, ankylosis, specific neurological defect, etc.)
- suspected internal lesions.

Finally, the medical report (which will not necessarily take the form of the final document subsequently submitted to the authorities) must make a statement on the compatibility of the lesions with the allegations made by the detainee.

The examination itself will be conducted according to circumstances, and each doctor proceeds according to his own customary methods. The one indispensable condition is not to forget anything, since in most cases it will not be possible to see the patient again for a long time.

The doctor should note which is the detainee's dominant hand, if possible without his knowledge, as it might prove useful information should the detainee be suspected of having inflicted the lesions himself.

When the ICRC doctor is making an expert report on lesions resulting from torture, he must not omit mention of all visible scars that the patient himself states are not due to torture. The inclusion of such statements enhances the authenticity of the final report.

It is useful, in our experience, to make a brief test of the mental faculties of all patients who are examined individually. This test should include at least the following features:

- orientation in time (date? day? year?)
- orientation in space (name of prison? which floor?)
- awareness of outside events (national news? family events?)
- simple mathematical calculations
- abstract reasoning.

This very limited mental test will enable the ICRC doctor to obtain an idea of his patient's mental state and, if necessary, check on it again during the next visit.

## 4. Conclusion

***Summary: In the medical field, as elsewhere, the ICRC does not attempt to take the place of the detaining authority.***

With regard to medical care, the ICRC doctor provides no treatment and cannot replace the doctor in the place of the detention. The work of the ICRC doctor is to make an overall evaluation of the situation, especially concerning diet and sanitation. He must analyse conditions in order to discover the reasons for any shortcomings. His

purpose is to co-operate with the local authorities to find specific and practicable solutions to the problems he has noted. With respect to ill-treatment, he must not only carry out a general survey of the phenomenon but must bring what solace he can to the victims he meets. This is done through personal contact, however brief, the "doctor-patient" relationship being a special occasion during which the doctor is able to provide information and advice and often to reassure the victim.

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**and**  
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# ICRC surgical activities

by

**Dr. Rémi Russbach**

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## **1. Background**

The surgical activities of the International Committee of the Red Cross stem from the institution's general mandate to protect and assist the victims of armed conflict.

The war wounded are thus only one category of the victims included in the ICRC's terms of reference.

The ICRC's main role in relation to the war wounded is not to treat them, for this is primarily the responsibility of the governments involved in the conflict and hence their army medical services. The task of the ICRC is first and foremost to ensure that the belligerents are familiar with the provisions of the Geneva Conventions and apply them, that is, care for members of the enemy armed forces as well as their own and afford medical establishments and personnel the protection to which they are entitled.

Nevertheless, local medical services are often completely overwhelmed in conflict situations and the ICRC is then compelled to step in to help the war wounded. When supplying hospitals with medical equipment and medicines is not enough, the ICRC has to set up its own surgical facilities to offer the wounded the care that the authorities cannot provide.

There was a sharp increase in conflict situations calling for direct ICRC assistance in the 1980s and the institution's surgical activities showed an unprecedented expansion. The number of wounded admitted to ICRC hospitals rose from 4,000 in 1987 to 18,450 in 1990. By the beginning of 1991 the ICRC was running 14 surgical establishments in eight countries, staffed by 22 surgical teams.

These various surgical units have developed along different lines, depending on the constraints imposed by the local context.

In Thailand, Pakistan, Afghanistan, Kenya and Somalia, the ICRC surgical hospitals are entirely autonomous. They are housed in ICRC premises and are staffed by expatriate personnel, backed up by local employees who work under ICRC supervision.

In such cases the ICRC has complete control over the system of treatment and can compile reliable statistics.

In other countries (Cambodia, Ethiopia), the ICRC's teams have to work in government-run hospitals and are limited to performing surgery, while the government retains responsibility for other services and for most of the nursing staff.

The ICRC has to ensure that in hospitals not under its control certain basic principles are respected so as to win the trust of the adverse party (no weapons or political activity in the hospital, no discrimination against enemy wounded). A recent example is the government hospital in Bahr Dar, where the ICRC was working under an agreement with the Ethiopian authorities incorporating those principles. When rebel forces overran the town they spared the hospital and let the ICRC team go on with its work in accordance with the same principles.

ICRC surgical hospitals differ considerably from army medical units in that the ICRC has no control over the system to evacuate the wounded and has no referral facilities. Each ICRC hospital therefore serves as both first-aid and final referral centre, thus forming an entity that has little in common with a military surgical unit.

The ICRC does, however, try to extend its activities to the prehospitalization phase and to organize adequate first-aid and transport.

It is not usually possible for ICRC staff to have access to the actual scene of the fighting, so arrangements for the prehospitalization phase have to be made through intermediaries.

With this in mind, the ICRC has set up several programmes to train first-aid workers belonging to groups involved in the fighting. The basic first-aid training given (dressing wounds, immobilizing fractures, stopping bleeding, rehydration, administration of antibiotics) is accompanied by an introduction to the elementary principles of international humanitarian law (ban on killing wounded enemies and prisoners, respect for civilians, etc.).

## 2. Organization

ICRC hospitals are designed to receive a large number of casualties at the same time. In the admissions area the patients undergo triage and resuscitation and are prepared for theatre. The patient's condition determines whether he or she requires haemoglobin estimation, cross-matching or radiography.

A blood bank is important when managing major injuries. In the situations in which the ICRC is working, blood for transfusion is often scarce. Donation of blood is encouraged among the local population and the patients' relatives; collection sessions are used as opportunities to disseminate the basic principles of the Red Cross and Red Crescent.

There may be cultural and practical obstacles to the collection of blood, and often widespread chronic anaemia in the local population is a further complication. Judicious use of the available blood is therefore essential. The general guideline is not to transfuse patients with a haemoglobin level above 7 g/dL. Before transfusion, each unit of blood is cross-matched and tested for malaria, syphilis, hepatitis B and HIV. The quantity of blood needed for war surgery has been established from experience; the average requirement in ICRC hospitals is 45 units per 100 patients admitted; this rises to 60 units if the patients are admitted within six hours of being wounded and to 100 if antipersonnel mines are widely used in the conflict concerned.

The radiographic service is limited to plain films, which are sufficient for preoperative assessment.

In an ICRC hospital, the operating theatre, postoperative ward, blood bank, laboratory and radiography unit are housed in permanent structures (brick, corrugated iron) with a concrete floor. The surgical wards and triage areas may be simple shelters or tents if the security situation permits. Thus bed capacity can be increased easily and rapidly.

The surgical equipment, drugs and nursing materials used are standardized. The standard list, drawn up by the ICRC Medical Division, ensures uniform management throughout the institution's hospitals; it avoids problems arising from different expectations and preferences on the part of medical personnel. This is particularly important in situations where the surgical teams rotate on a three-month basis. The standard list is regularly reviewed. The principle on which it is based is to provide only items essential for managing war wounds, such as basic instrument sets and equipment for safe anaesthesia.

The ICRC hospitals also provide a physiotherapy service, outpatient review and, later, rehabilitation. The hospitals are run by both expatriate and local staff. The medical personnel are recruited through National Red Cross and Red Crescent Societies; each surgical team consists of a surgeon, an anaesthetist and an operating theatre nurse.

### **3. Triage**

The capacity to deal with a large number of patients admitted within a short period may be limited by the operative facilities. In such circumstances it is necessary to determine which patients have high priority for treatment. The triage officer should preferably be an experienced doctor; it can be difficult to come to terms with the concept that the most severely wounded may not have top priority. Category I comprises those who need urgent surgery but who have a good chance of survival. Category II includes both patients who do not require surgery for their wounds and those who are so severely wounded that surgery would not help and would take up excessive surgical resources. Category III comprises those who can safely await surgery. Frequent reassessment is necessary, as inevitably some patients with hopeless prognoses improve while others may deteriorate. Rational triage is of paramount importance to achieve “the best for the most”.

### **4. Wound management**

Wounds from fragments or bullets may be small, requiring little or no surgery. Those with significant tissue damage, however, are usually heavily contaminated and pieces of clothing or skin are pushed or sucked into the wound. With mine injuries, the victim may suffer traumatic leg amputation while stones, mud and bone fragments are blown up into the thighs, buttocks or genitals.

The surgical aims are to remove all the foreign materials and loose bone fragments, to excise the devitalized tissue and to decompress the viable tissue that remains. The wounds are then left open and dressed with sufficient quantities of loose gauze to absorb the blood and serum exudate. The dressing remains undisturbed until the date for delayed primary closure (four to five days), unless the general condition of the patient indicates that the wound has been incompletely excised. Delayed closure may be by direct suture, skin graft or reconstruction. For limb wounds, correct wound management has a higher priority



than the method of fracture fixation; external skeletal fixation has proved popular with surgeons but there is growing recognition of the efficacy of simpler means such as plaster of Paris.

## **5. Training of civilian surgeons for war surgery**

The ICRC Medical Division recognizes that the transition from specialized civilian surgical practice to the management of war wounds may be difficult for many surgeons. They are faced with different working conditions, equipment, pathology and patient expectations. Moreover, they are working outside the speciality for which they have been trained.

A course for surgeons is held every year and has proved a popular forum for exchanging information and experience. Surgical briefing material has been distributed to all National Red Cross and Red Crescent Societies that recruit surgeons. There have been many publications documenting the ICRC's experience in war surgery (*see below*), the aim of which is to establish a process of internal evaluation to improve professional performance. Such publications are proving a valuable means of contact between the Medical Division and professional bodies, National Red Cross and Red Crescent Societies and armed forces medical services which could benefit from ICRC experience.

In addition, there is growing recognition that the experience gained by individual surgeons on ICRC missions is beneficial to their civilian practice and, in the case of younger surgeons, it is an asset for their curriculum vitae. Indeed, in modern surgical training there is little opportunity to experience true general surgery; the ICRC provides that opportunity.

## **6. Conclusion**

The ICRC Medical Division, while continuing to expand its surgical activities, is at the same time endeavouring to retrieve this field experience for the benefit of others who have to manage war-wounded patients.

**Dr. Rémi Russbach**  
**Dr. Robin Charles Gray**  
**Dr. Robin Michael Coupland**

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# Thirteen years' experience in fitting war amputees with artificial limbs

by Alain Garachon

From its very beginnings the ICRC has been concerned with the war disabled and has done what it can to help them. After the Second World War it was involved in orthopaedic activities in various countries, such as Finland, Viet Nam, Jordan, Hungary, Algeria, Morocco, Israel, Egypt, Nigeria, Somalia and Yemen.

At the time such work was carried out by specialized firms using the technology of industrialized countries, but during the 70s the ICRC and WHO set up an orthopaedic programme in Yemen based on the local manufacture of orthopaedic components, to avoid having to rely on imports.

This policy, which was widely adopted by international cooperation agencies and even laid down as a principle under the general heading of "appropriate technology", led some experts to go to the other extreme of advocating techniques too remote from the basic requirements of the profession, although they appeared quantitatively more attractive in satisfying an ever-growing demand.

Over the past thirteen years, the ICRC has established 24 orthopaedic workshops in 14 countries. They have produced:

● prostheses	37,000
● orthotic appliances	11,000
● wheelchairs	3,400
● pairs of elbow crutches	68,000

Fifty-three expatriate associates, mainly prosthetists, were engaged in this work in 1990, together with some 300 local assistants.

In all programmes of this type, the ICRC endeavours to develop techniques and components appropriate to the economic capacity of the countries concerned, and has succeeded in designing and producing artificial feet and knees using local materials.

In many countries, however, basic raw materials such as wood and leather are becoming ever scarcer and more expensive. In Angola, for example, suitable wood costs US\$ 3,000 per cubic metre.

This situation has recently led the ICRC to employ cheap synthetic materials, such as polypropylene, along with local materials, of course, whenever these are available at a reasonable price.

In certain countries with many amputees (for example Viet Nam, whose authorities cite the figure of 60,000), machine tools of simple design have been developed for the mass production of artificial knees. This has the additional advantage of ensuring a degree of standardization in the quality of the finished product.

In a case such as Viet Nam, if one takes a figure of only 40,000 amputees and an annual production of 10,000 artificial limbs, each with an estimated life of four years, it would take four years to fit all the amputees and production would have to continue at the same rate. At least 200 prosthetists would be needed to maintain such an annual output!

Even in Angola or Afghanistan, where its output is highest (about 1,500 prostheses annually in each country), the ICRC is far from achieving such figures.

The other aspect of ICRC work in this sphere is *the training of local prosthetists*. The training courses comply as far as possible with the recommendations of the International Society for Prosthetics and Orthotics (ISPO), which has established various levels of training for developing countries. In general, trainees are prepared for level II, a three-year course. Level I is more or less equivalent to the training given in European countries.

Training programmes are carried out in close cooperation with the Ministries of Health concerned. Where this is not already the case, the latter are encouraged to give official recognition to the profession of prosthetist/orthotist to assure the future and further training of new graduates. Practical and theoretical courses are conducted by expatriate prosthetists and physiotherapists and also by local technical teachers and doctors. The final examinations are supervised by the teachers who run the courses and a representative from the ISPO. Appropriate training is also given to assistant prosthetists and craftsmen specializing in the manufacture of components.

The purpose of these programmes, apart from fitting as many amputees as possible, is to make the workshops technically and administratively independent so that the ICRC can eventually phase out its involvement.

Experience over the past twelve years has shown that good expatriate professionals are capable not only of fitting patients but also of manufacturing components and teaching, thus enabling their local counterparts to achieve a satisfactory level of technical independence. The same cannot be said, however, of administrative independence, over which the ICRC has no control after the hand-over.

Indeed, factors such as political will, operational budgets, administrative competence and working conditions are vital to the success or failure of a programme, irrespective of the technical level of the staff.

Many countries have insufficient resources to ensure a regular supply of local and imported materials and to pay their employees a decent salary. The latter are then compelled to take a second job in order to survive, or they leave the workshops.

The ICRC is now concentrating on these "administrative" aspects, in order to preserve programmes which took so much time and effort to implement.

Not all countries are prey to such difficulties, however, and very satisfactory results have been achieved in some of them: Yemen, Pakistan, Zimbabwe, Chad and Burma. Elsewhere, in Angola, Mozambique, Nicaragua, Ethiopia, Sudan, Uganda and Lebanon, despite the sound technical level of the staff, the ICRC has to maintain a presence in order to compensate for the administrative shortcomings of its partners.

In Viet Nam and Afghanistan, where programmes have been set up more recently, the ICRC's local counterparts have not yet reached the stage of technical self-sufficiency. It is regrettable in this connection to note that international cooperation agencies are interested first and foremost in the technical aspects of orthopaedic activities. Without underrating the importance of this, we feel that it is essential to attach equal importance, if not top priority, to ways of integrating such programmes into local structures so that long-term success is assured.

**Alain Garachon**

**Mr. Alain Garachon**, who was born in Paris in 1942, obtained a degree in physiotherapy in France in 1964 and practised physiotherapy in Paris between 1967 and 1975. He was seconded by the French Red Cross to work for the ICRC in Biafra, Bangladesh and Lebanon (1969, 1972, 1977) and was also employed in a spastic children's centre in Melbourne (1976). Since 1978 he has been in charge of the War Disabled Rehabilitation Service within the ICRC Medical Division.

# Strategy for medical assistance in disaster situations

by Dr. Pierre Perrin

Disasters create specific problems shaped by both the type of event (earthquake, volcanic eruption, war) and its consequences (sudden or gradual impact on the victims).

The process that unleashes a disaster is often more complex than appears at first glance. For example, drought is obviously caused by poor climatic conditions, but it may also be precipitated by human behaviour detrimental to the environment.

While internal conflicts do not always have a direct and major impact on civilians beyond the casualties they claim, the breakdown of local services,<sup>1</sup> particularly medical care and food supply, may have dire effects on health and nutrition, so that the entire civilian population falls victim to the situation.

The consequences are no less complex. Disaster was long defined as the result of a sudden disruption in living conditions preventing the population from meeting its basic needs.

On the basis of this definition, outside assistance was considered the only adequate solution and little attention was paid to local mechanisms of adaptation and response.

Today greater emphasis is placed on the predominant role that local institutions and communities can play in coping with disasters, while outside aid is viewed as a means of supporting local efforts rather than substituting for them.

This approach<sup>2</sup> has proved its merit in the case of natural disasters.<sup>3</sup> Indeed, several studies carried out in the aftermath of earthquakes

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<sup>1</sup> Local services tend to break down in conflict situations owing to the fact that human and financial resources are diverted to the military sector, which takes priority.

<sup>2</sup> The new approach has in fact long been advocated by "responsible" disaster relief agencies.

<sup>3</sup> The word "natural" is used here in opposition to "conflict-related", and not to define the cause of the disaster.



have shown that assistance provided by the local community is more effective than relief airlifted from abroad.

In conflict situations, however, this approach is hampered by political constraints, which often slow down or limit the local response. In such situations, outside assistance<sup>4</sup> is important primarily for its protective value and only secondarily in providing technical expertise to cope with the material effects of the conflict.

In this paper we shall examine only the problem of organizing humanitarian aid for civilians in conflict situations. Assistance to other categories of victims, such as prisoners of war and civilian internees, will be dealt with elsewhere.

Various aspects of the subject are discussed below in the following logical order:

- Survey of the situation
- Defining priorities and aims
- Providing assistance
- Complementarity
- Evaluation of results.

## SURVEY OF THE SITUATION

### A. “Snapshot”

The aim of a preliminary survey is to identify problems that require ICRC intervention. The type of activities undertaken by the institution will depend on the urgency of the problems, their seriousness and the constraints inherent in each situation.

The key words “problems, activities, constraints” must first be defined.

**Problems** arise when local systems can no longer meet the basic needs of victims for reasons that are either material (lack of resources and personnel) or political (no access to health services and food supplies). Two parameters are useful in assessing these problems:

— seriousness: in the medical field, morbidity and mortality rates;

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<sup>4</sup> Provided, in conflict situations, by the ICRC.

— proportions: obviously, the greater the number of victims, the greater the risk that local services will be overwhelmed.

*Activities* should be understood in the broadest sense, that is, as including all efforts to meet the victims' basic needs. Direct assistance is only one activity among many, such as guaranteeing access to local health services for people who would otherwise be cut off from any medical care.

*Constraints* are of many kinds, for example political (poor conditions, reasons of State, lack of access to victims), technical (absence of appropriate situations for a given problem), logistic (limited means of transport) and financial.

This broad definition of a preliminary survey has the advantage of taking into account not only the victims' state of health, but also the capacity of local facilities and the constraints under which they are operating. Such information is of great value in determining whether and in what way the ICRC should take action.

The results of surveys carried out in the midst of conflicts, unlike those taken in normal conditions, tend to be of ephemeral value owing to the instability of the situation, which is characterized, for example, by:

- considerable fluctuations in the number of victims
- changes in the geographical distribution of the victims.

A preliminary survey should therefore be seen as a sort of "snapshot" of the situation at a given moment if the results are to be interpreted correctly. This must then be placed in its proper context, hence the need to determine the causes of the situation and its possible evolution.

## **B. Causes**

To determine the causes of a disaster is more than a purely intellectual exercise, since they will have a considerable influence on the ICRC's choice of activities to be undertaken.

It would be hazardous, for example, to plan a food distribution on the basis of a "snapshot" of the nutritional state of victims at the time

of the survey without taking into account the social context,<sup>5</sup> the season,<sup>6</sup> and various political factors.<sup>7</sup>

The causes also have a bearing on the medium-term planning of relief activities. For example, where food shortages are due to lack of seed, the appropriate response is to distribute food, but this should rapidly be followed by the provision of seed to enable the victims to regain a measure of self-sufficiency.

## C. Possible evolution

A “snapshot” of the situation and preliminary assessment of its causes may be considered fairly objective since they are based on information which, albeit not always totally reliable, paints at least a relatively realistic picture.

Any assessment of the possible evolution of the situation, on the other hand, is a matter of guesswork since future events are determined mainly by political factors. It is frequently impossible to predict the duration of a conflict or its intensity even one or two weeks in advance.

Yet it is essential to take future developments into account in deciding on the type of action to be taken.

For example, wherever a conflict is likely to change course at short notice and local surgical facilities appear unable to cope with a sudden influx of wounded, an independent surgical unit should be set up. In many instances experience and common sense must take the place of factual information.

Various problems may arise:

- numerous wounded and poor surgical facilities
- severe malnutrition and disrupted access to food
- widespread diarrhoeal diseases and contaminated water

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<sup>5</sup> These findings must be compared with the normal situation in the country.

<sup>6</sup> In the case of rural populations in developing countries, seasonal fluctuations in malnutrition rates must be taken into account. These correspond to normal variations in the availability of food at the family level.

<sup>7</sup> Malnutrition may stem from a situation in which access to food supplies has been disrupted for political reasons. In such cases ICRC efforts focus on restoring the food supply rather than distributing substitute rations.

- overpopulation and epidemics in camps for displaced people
- numerous unaccompanied minors and disintegration of social structures.

It remains to be established which problems will take priority, depending on their seriousness and proportions and on the constraints that determine what can be done in a given situation.

## **DEFINING PRIORITIES AND AIMS**

In practical terms, three major aims should be given priority in emergencies, namely:

- ensuring access to food supplies;
- providing a healthy environment;
- guaranteeing access to health services.

All possible courses of action must be weighed in relation to these overall aims, and the most effective and feasible chosen.

### **1. Ensuring access to food supplies**

The ICRC's activities are dictated by its mandate to protect victims, conferred on it by the Geneva Conventions.

Guaranteeing access to food therefore involves not only direct distributions to conflict victims, but also protecting their own food resources, ensuring access to the means of food production and reminding the parties involved of the ban on the use of famine as a method of warfare.<sup>8</sup>

Accordingly, the ICRC's operational objectives may be to:

- Negotiate with the authorities concerned free access by the population to the means of agricultural production;<sup>9</sup>

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<sup>8</sup> Article 14 of Protocol II additional to the Geneva Conventions, which pertains to the protection of objects indispensable to the survival of the civilian population, provides that: "Starvation of civilians as a method of combat is prohibited. It is therefore prohibited to attack, destroy, remove or render useless, for that purpose, objects indispensable to the survival of the civilian population, such as foodstuffs, agricultural areas for the production of foodstuffs, crops, livestock, drinking water installations and supplies and irrigation works".

<sup>9</sup> On the Angolan Planalto, the reduction of the area available for cultivation owing to dangerous conditions and the fact that farmers were prohibited from going beyond certain boundaries has deprived people of part of their normal food supply.

- Distribute food when it cannot be obtained locally, but only as a last resort;<sup>10</sup>
- Meet the special requirements of the malnourished;
- Provide the means to resume agricultural production.

Thus to achieve a single overall aim entails numerous activities ranging from negotiating permission to carry out food distributions to setting up nutritional and agricultural rehabilitation programmes.

## **2. Providing a healthy environment**

The objective of providing a healthy environment may also be subdivided into various areas of concern:

- water
- habitat
- waste.

Water being vital to life, a significant shortage represents an immediate threat. The operational objectives in this respect are based on criteria of quality<sup>11</sup> and the quantity required per person.<sup>12</sup>

Habitat is taken in the broad sense, including the choice of a re-settlement area for people who have been displaced by a conflict. That choice must be based on a thorough analysis of security and hygiene conditions, and proper arrangements must be made for waste disposal.

## **3. Guaranteeing access to health services**

The ICRC endeavours to ensure that hospitals and dispensaries remain accessible at all times to anyone needing treatment. It may request neutral status for such facilities where necessary to guarantee the security they need to continue functioning.<sup>13</sup>

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<sup>10</sup> The ICRC has carried out many food distribution programmes. In 1985 it provided food for over 800,000 people in Ethiopia.

<sup>11</sup> At the very least, water must be free from enteric colibacilli.

<sup>12</sup> For example, the standard amount considered necessary in camps for the displaced is 20-25 litres per person per day.

<sup>13</sup> The ICRC has obtained neutral status for many hospitals in conflict situations, most recently in Lebanon and Sri Lanka.

Recognition of the importance of public health has opened the way to preventive activities, broadening the scope of health services. Prevention is given particular importance by the ICRC, which works among people living in precarious conditions (such as camp dwellers and rural African populations), since it is the best way to maintain minimum health standards.

The overall aim is thus to ensure access to health services for:

- medical treatment;
- preventive health care.

## PROVIDING ASSISTANCE

Definition of intermediary aims helps in setting operational objectives, which in turn point to practical activities.

The following examples are by no means exhaustive. They are intended merely to illustrate the breakdown of an overall goal into operational objectives.<sup>14</sup>

**1. *To meet the special needs of the malnourished*** means to:

- detect cases of malnutrition;
- open a nutritional rehabilitation centre;
- supply the food necessary for the centre;
- set public health standards for the centre.

**2. *To ensure an adequate water supply*** means to:

- choose a water source;
- mobilize the resources necessary to exploit it;
- set up a distribution network.

**3. *To prevent disease*** means to:

- vaccinate children against measles:
  - set up a cold chain;
  - train personnel to give vaccinations;
  - inform local authorities of the time and place of vaccinations;

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<sup>14</sup> This is only a broad outline which does not deal with quantitative aspects, such as the number of people to be reached, the target nutritional level and the time available.

- promote the use of rehydration salts;
- set up a community health education programme.

**4. To prepare for evacuating the wounded** means to:

- identify hospitals that can take in wounded;
- assess the human and material resources of those hospitals;
- draw up an emergency contingency plan to deal with any massive influx of victims.

We shall not go into further detail here about the specific tasks which each of the above activities entails, but this is the next step in determining the resources to be mobilized.

## **COMPLEMENTARITY**

At the outset it should be emphasized that for assistance to be effective, the way that relief agencies perceive the victims' situation and needs must correspond to the victims' own perceptions and demands.

### **1. Complementarity between programmes**

A nutritional rehabilitation programme for malnourished children must be accompanied by efforts to ensure that their families have access to basic food supplies, otherwise these children will inevitably relapse into a state of malnutrition.

Food and water supply programmes and vaccination campaigns contribute substantially to disease prevention and thus reduce pressure on medical services. Complementarity between preventive measures and treatment is of both ethical<sup>15</sup> and financial importance.<sup>16</sup>

### **2. Complementarity between assistance and development activities**

How often has emergency assistance been criticized for being unproductive, that is, for creating chronic dependence rather than promoting development?

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<sup>15</sup> Why wait until people fall ill when disease can be prevented?

<sup>16</sup> A healthy person is less of a financial burden than a sick one.

Efforts have recently been made to resolve this dilemma, in particular by setting up many agricultural rehabilitation programmes involving the distribution of seed and tools.

Such programmes are examples of emergency assistance that restores a measure of self-sufficiency in food and thereby avoids the need for repeated food distributions, which are not only very expensive but also reduce the victims to a state of permanent dependence.

However, such programmes cannot be considered as contributing to development. This becomes clear when one analyses the causes of this type of disaster.

Severe malnutrition in a rural population that has fled a conflict area is directly attributable to displacement, disruption of access to customary food supplies and a breakdown of social structures.

*Nutritional rehabilitation* provides a remedy for the ultimate consequence of the crisis, namely its physical effects on the most vulnerable members of the population.

*Food distributions* help families by providing them with enough food to survive.

The *distribution of seed and farming tools* encourages people to return to their places of origin. It has an impact not only on families (restoration of self-sufficiency in food), but also on communities (return of the group to its place of origin) and agriculture (resumed production), but does not bring about any fundamental change in lifestyle.

All these activities tend merely to restore the situation that prevailed before the crisis.

The root cause of the crisis may well have been the population's vulnerability in the first place to the dangers of political instability, climatic variations, or a combination of both.

In economically developed societies, only extreme political upheavals have any bearing on the general nutritional state.<sup>17</sup> In developing countries, however, the rural population usually lives in such precarious conditions, barely at survival level, that any disruptive factor such as a conflict thrusts it into a downward spiral of reduced agricultural production, migration, malnutrition and, for the most vulnerable, death.

Development activities should address this basic vulnerability by giving the population the means to withstand the effects of crises such as war and drought. This does not only mean increasing agricultural

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<sup>17</sup> The most recent example in Europe was probably the Second World War.



production; traditional self-help mechanisms should also be strengthened.

However, it should not be forgotten that the development process may entail a reassessment of working conditions, social and cultural relations and the prevailing political system — a considerable challenge at any time, especially in the midst of a conflict.

### 3. Complementarity between agencies

It is by far preferable, in the interest of disaster victims, to speak of complementarity rather than competition among relief agencies. This complementarity may be based on a division of tasks according to geographical regions, categories of victims or stages in the crisis — certain agencies carrying out emergency activities and others taking over as soon as the situation permits in order to promote development.

The ICRC's obvious partners are the National Red Cross and Red Crescent Societies. While the institution usually plays a key role in the acute phase of a crisis, it should shift its focus as soon as possible to supporting the activities of National Societies on behalf of the most vulnerable groups.

## EVALUATION OF RESULTS

The evaluation stage is often the weak link in emergency operations, not because it is difficult to trace what happened to the resources mobilized, but because it is never easy to show that a particular activity had the desired impact on the situation of the victims.

This shortcoming is due to the following factors:

- First of all, *the difficulty in obtaining reliable information*. Although there are many indicators of a population's state of health, these are accurate only insofar as they are carefully and regularly monitored, which is virtually out of the question in an emergency situation.
- Secondly, *lack of insistence on the part of the donors*. Indeed, donors are generally more concerned about the administrative implications of their contributions than on the actual effect they have on the state of the victims. As a result, relief agencies tend to be somewhat lax in analysing the true impact of their operations.

## CONCLUSION

Most humanitarian organizations focus on one specific sphere of activity, for example nutritional assistance (SCF)<sup>18</sup> or medical care (MSF),<sup>19</sup> or one specific group of victims, such as women and children (UNICEF) or conflict victims (ICRC).

However, they usually try to integrate their activities within a global strategy taking into account all the basic needs of the victims. Where their personnel has been trained to adopt such an integrated approach, field work stands a far greater chance of being successfully coordinated.<sup>20</sup>

Greater emphasis should in any event be placed on assessing the effect of humanitarian activities on the victims' situation, since this is the only reliable way of identifying the shortcomings of the strategy adopted and modifying it accordingly.

**Dr. Pierre Perrin**

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<sup>18</sup> Save the Children Fund.

<sup>19</sup> *Médecins sans Frontières*.

<sup>20</sup> See "Training medical personnel: HELP and SOS courses", pp. 505-512.

# Training medical personnel: HELP and SOS courses

by Dr. Pierre Perrin

## 1. The need for training

The early 1980s marked a turning point for humanitarian aid. During those years most of the major emergency relief agencies became aware that steps were needed to heighten the efficiency of their assistance to disaster victims.

New policies were therefore introduced to:

- promote preventive measures,
- codify assessment methods,
- standardize medicines and equipment,
- rationalize intervention criteria, and
- improve coordination among humanitarian organizations.

These policies could not be fully effective unless special training was given to the personnel in charge of putting them into practice. In 1985 the ICRC Medical Division therefore began organizing courses to:

- 1. train experienced medical personnel for emergency interventions by the ICRC and other relief organizations in disaster situations;*
- 2. develop a common approach allowing better programme coordination between the various humanitarian organizations involved;*
- 3. define the conditions and skills required to extend immediate assistance projects and adapt them to situations requiring medium- and long-term planning.*

It was with these objectives in mind that the ICRC, the World Health Organization (WHO) and the Faculty of Medicine of Geneva University decided to organize a course specifically for senior medical personnel.

The first HELP<sup>1</sup> course was held in June 1986.

## 2. Participants

Course participants are selected according to three main criteria:

- professional experience in emergencies;
- a diploma in one of several specialized medical subjects;
- the explicit desire to continue work in the humanitarian field.

For pedagogical reasons<sup>2</sup> no more than 25 participants are admitted to the course, which is held on an annual basis in order to satisfy the great demand<sup>3</sup> and always takes place at the same time of year in Geneva (June-July).

After the first four courses it became evident that the geographical distribution of participants was very uneven. This was attributable to several factors, mainly the working language (English) and the cost. To remedy the situation the ICRC decided to offer the same course in Spanish and French and help participants obtain scholarships so as to enable a wider range of applicants to attend, in particular medical personnel from the National Red Cross and Red Crescent Societies of developing countries.

The ICRC organized a first course in Spanish, called SOS<sup>4</sup>, in 1990 in close cooperation with the Pan-American Health Organization (PAHO)<sup>5</sup>, which generously provided scholarships for 24 participants. An SOS<sup>6</sup> course in French will be held in September 1991 in Brussels to train French-speaking medical personnel, in particular from West Africa, eastern Europe and South-East Asia.

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<sup>1</sup> Health Emergencies in Large Populations.

<sup>2</sup> The course is taught on an interactive basis, i.e. with a high level of student participation.

<sup>3</sup> On average 70 applications yearly in the first four years.

<sup>4</sup> Salud en Operaciones de Socorro.

<sup>5</sup> WHO regional office for the Americas.

<sup>6</sup> Santé dans les Opérations de Secours.

The first SOS course in Spanish helped to achieve a more balanced geographical distribution of participants, as can be seen in *Table 1*.

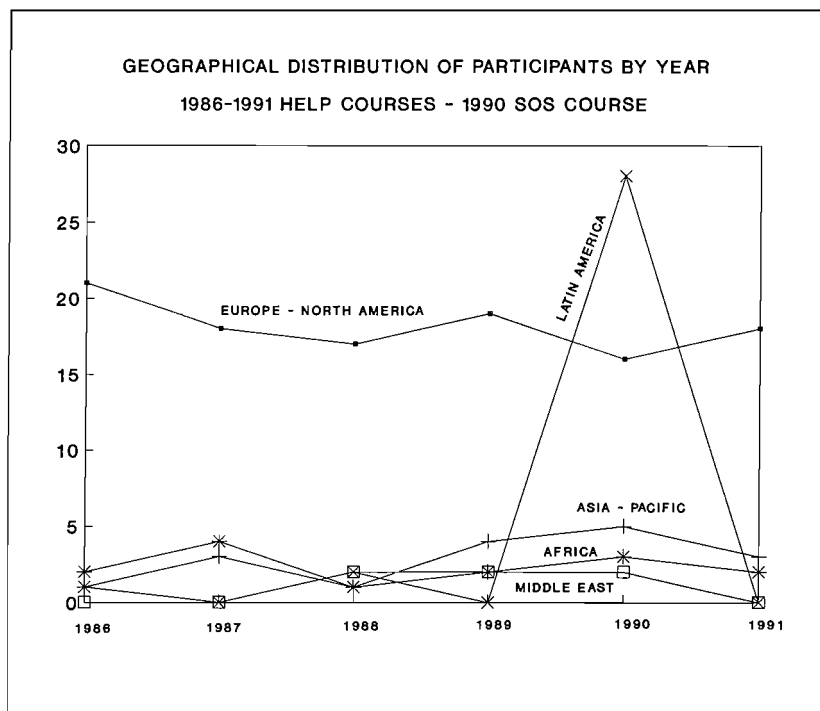


Table 1

A total of 177 people from 55 countries took part in HELP/SOS courses from 1986 to 1991.

The typical HELP course participant was male (66%)<sup>7</sup>, 38 years of age and had considerable professional experience, including on average four humanitarian aid missions.

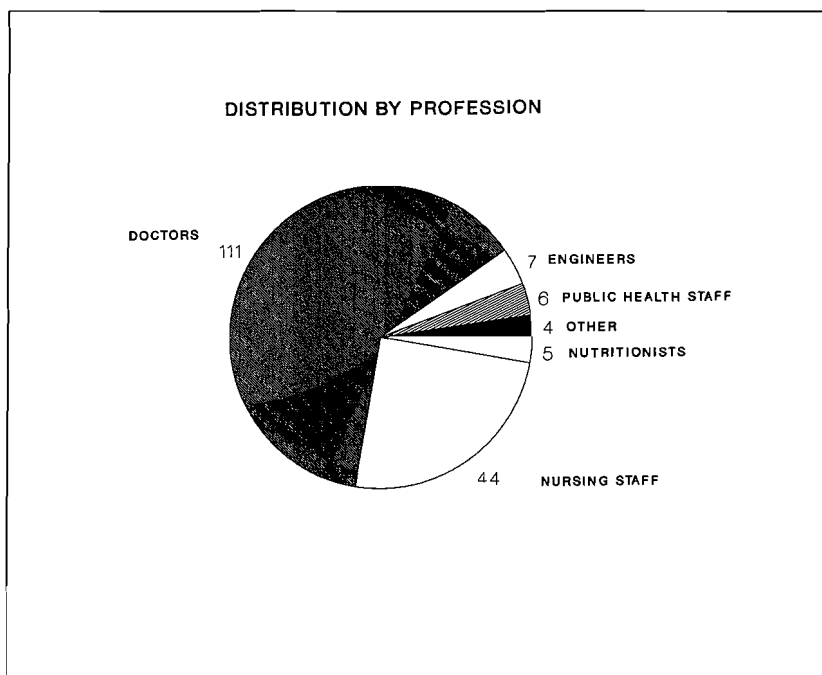
The distribution by profession, which can be seen in *Graph 1* (p. 508) to be very uneven, shows a large majority of doctors (62%).<sup>8</sup>

In their assessments, participants indicated that they would prefer applicants without any medical training to be excluded from the course.

<sup>7</sup> For the first time there were more female than male participants in the 1991 HELP course.

<sup>8</sup> More nursing staff than doctors attended the 1991 HELP course.

One of the course's main objectives is to prepare participants to work with members of other organizations.



Graph 1

Of the 177 participants shown in *Graph 2* (p. 509), nearly one half (48%) worked within the Red Cross and Red Crescent Movement (ICRC, League and National Societies).

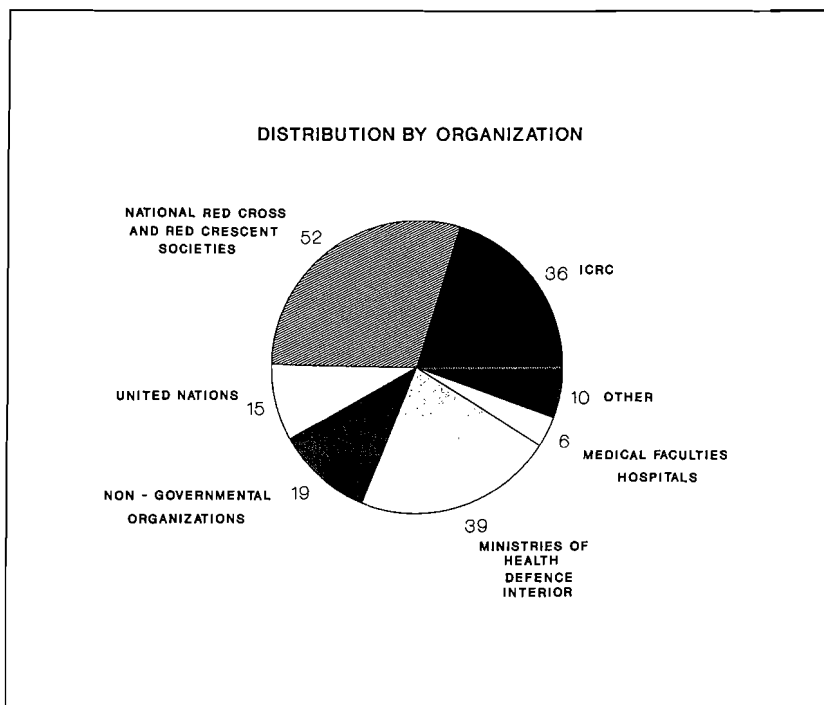
The majority of participants from ministries were sent by WHO and PAHO.

Permanent WHO, UNHCR and UNICEF staff also took part in the courses.

### 3. Course contents

For practical reasons the course has been divided into units corresponding to the following major fields of emergency activity:

- planning;
- food and nutrition;



Graph 2

- environmental health;
- communicable diseases;
- organization of health services;
- epidemiology;
- learning methods;
- international humanitarian law.

Additional course units on more specific subjects were later introduced, for example surgical *triage* (a practical exercise), relations with the media and development.

The contents of some course units have been modified over the years to keep pace with technical progress. To take a striking example, WHO experts taking part in the course have helped to update the teaching in the unit on communicable diseases of methods for the control of specific diseases.

## 4. Assessment

### (a) Course assessment

Participants are invited to assess the course according to the following three criteria:

- relevance of the curriculum,
- quality and appropriateness of the teaching methods,
- skill of the instructors.

The assessments are summarized in a final report and serve as a basis for introducing changes into the following course.

### (b) Determining the impact of the course

#### *Quantitative impact:*

One of the purposes of the course is to train people who will return to the field. To see whether this purpose had been achieved, a questionnaire was sent out in 1990 to all former HELP participants. Of the 42 respondents, 75% said that they had returned to the field. Among the 17 ICRC medical coordinators working throughout the world in July 1990, nine had taken part in a HELP course.

#### *Qualitative impact:*

It is very difficult to devise a method of assessment that provides an accurate answer to the question:

#### ***Are former HELP participants more effective in the field?***

The objectives of the course are all related to developing the analytical skills necessary to handle emergencies, and to improve co-ordination and dialogue among the staff of various organizations.

Any course assessment must take into account the quality of field work. Former participants are therefore asked to write a report on a mission carried out after they have completed the course with special focus on their use of the knowledge acquired in the course.

An official diploma is issued once this report has been approved by the Faculty of Medicine. To date twelve reports have been submitted and only four diplomas awarded.





## 5. Conclusion

The now irreversible trend towards professionalization in the humanitarian field must not be viewed as a move away from the Red Cross ideal of spontaneous humanitarian assistance.

***All humanitarian assistance, no matter how spontaneous, must be effective.***

Although not all National Societies have yet been able to send personnel to attend HELP/SOS courses (see *Table 2, p. 511*), the recent decentralization of the courses and their availability in three languages (English, French or Spanish) should help to remedy this shortcoming.

A special effort must be made to ensure that staff of National Red Cross and Red Crescent Societies of developing countries are able to attend these courses.

**Dr. Pierre Perrin**

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# International health assistance in relief operations: preparing local health personnel to meet the challenge

by Dr. Claude de Ville de Goyet

## Introduction

Disasters are not merely very large accidents. They imply complex public health problems that must be resolved under difficult circumstances: society's normal coping mechanisms are disrupted; the high visibility and critical coverage provided by the mass media make the situation politically sensitive; logistic nightmares abound; the multi-agency response from outside the affected area is often poorly coordinated. In short, decision-making in a climate of uncertainty is the norm. *Information* management, not the *medical* management of patients, is often the main challenge facing health managers and volunteers in the initial or relief stage of a disaster.

The concept of disaster management has evolved considerably in the last two decades. In the early 1970s, the international community was barely recovering from the highly-publicized relief efforts to aid the victims of the Biafra-Nigeria civil war, when it was shocked by the news of an unprecedented cyclone and tidal wave in Bangladesh. The death toll reached 250,000, and relief operations faced insurmountable logistic and administrative problems.

## International relief and response

As a result of this chain of events, innovative measures were taken to ensure a better international response: the United Nations Disaster Relief Office was created in Geneva, a Research Center on Disaster Epidemiology was established, and the Red Cross and Red Crescent Societies strengthened their international response mechanisms.

At the time, the situation appeared simple: what was needed was *better* emergency relief. If relief agencies such as the League of Red Cross and Red Crescent Societies and other NGOs were more effective, then international agencies and health ministries of the various countries could concentrate on “serious” issues such as long-term development of health services or extending primary health care coverage.

Simple, it was not! In spite of an explosion of new non-governmental agencies in the field of medical and health emergency relief, the disaster death toll kept climbing. International chaos and overlapping assistance did not appear to decrease. Besides, uncontrolled “technological progress” was creating new threats, such as the chemical accident in Bhopal, India, and the Chernobyl nuclear accident, which was a minor incident in terms of *immediate* health effects, but an ominous warning for the future. Perennial threats — earthquakes, hurricanes, cyclones, floods, drought, locusts — did not fade away. On the contrary, rising population, poverty and numerous conflicts dramatically aggravated the consequences of natural disasters.

From the far corners of the world, the mass media’s instant coverage exposes even the most remote disaster, highlighting not only the suffering of the affected population but also the shortcomings of the national authorities. This, in turn, triggers an influx of international aid into the country. Too often, it is the wrong thing, at the wrong place or at the wrong time.

However altruistic it is meant to be, this generous aid does not achieve its anticipated results if decision-makers base appeals on non-humanitarian criteria or if the type of aid reflects preconceived ideas, traditionally held by the public in donor countries, such as these:

### **Myths and Realities of Natural Disasters**

**MYTH:** Foreign medical volunteers with any kind of medical background are needed.

**REALITY:** The local population almost always provides immediate first aid. Only medical personnel with skills that are not available in the affected country may be needed.

**MYTH:** Any kind of international assistance is needed, and it's needed now!

**REALITY:** A hasty response that is not based on an impartial evaluation only contributes to the chaos. It is better to wait until genuine needs have been assessed.

**MYTH:** Epidemics and plagues are inevitable after every disaster.

**REALITY:** Epidemics do not occur spontaneously after a disaster and dead bodies will not necessarily cause catastrophic outbreaks of disease. The key to preventing disease is to improve sanitary conditions and educate the public.

**MYTH:** Disasters bring out the worst in human behaviour.

**REALITY:** Although isolated cases of anti-social behaviour exist, the majority of people respond spontaneously and generously.

**MYTH:** The affected population is too shocked and helpless to take responsibility for its own survival.

**REALITY:** On the contrary, many find new strength during an emergency, as evidenced by the thousands of volunteers who spontaneously united to sift through the rubble in search of victims after the 1985 Mexico City earthquake.

**MYTH:** Disasters are random killers.

**REALITY:** Disasters strike hardest at the most vulnerable group, the poor — especially women, children and the elderly.

**MYTH:** Housing disaster victims in temporary settlements is the best alternative.

**REALITY:** It should be the last alternative. Many agencies use funds normally spent for tents to purchase building materials, tools, and other supplies in the affected country.

**MYTH:** Things are back to normal within a few weeks.

**REALITY:** The effects of a disaster last a long time. Disaster-affected countries deplete much of their financial and material resources in the immediate post-impact phase. Successful relief programmes make provision for the fact that international interest wanes as needs and shortages become more pressing.

Slowly, the international pendulum has swung toward disaster preparedness, focusing attention and modest resources on the urgent task of improving the disaster preparedness of the health sector, National Red Cross/Red Crescent Society and local communities in a vulnerable country.

## **Local preparedness**

Preparedness implies recognizing the possibility of a disaster and its expected impact on public health. It includes measures to improve the *readiness* of the health sector by defining the respective roles of the various institutions, strengthening their capacity to deal with disasters, and engaging in contingency planning, drills and simulation exercises, and disaster-management training. The expected outcome: a prompt and efficient response in case of disaster.

### ***Risk mapping***

The first step is for countries, cities and communities to identify the risks to which they are exposed. Are earthquakes a threat, volcanic eruptions, floods, drought or perhaps snowstorms? What type of hazardous substances are transported or manufactured in the area? Neither Red Cross/Red Crescent Societies nor health ministries alone have this specialized information to plot on maps. Risk mapping is a multidisciplinary task that requires the input of geologists, meteorologists, hydrologists and other experts. A technical inventory of all potential hazards that threaten a community is essential. Indeed, the value of preparing oneself against unknown risks is questionable!

### ***Vulnerability analysis***

A community's vulnerability is made up of social factors that predispose it to suffer the health consequences of the hazard. Everyone, rich or poor, living around the Pacific Rim of Fire is *exposed* to the same risk or probability of experiencing an earthquake of magnitude 7 on the Richter scale. However, not everyone will be *affected* equally. Those who live in poor or neglected areas, in unsafe, substandard constructions, are the most likely to suffer health consequences.

A vulnerability analysis will come up with possible or probable public health scenarios for different types or magnitudes of hazards. Speculative by nature, scenarios open the door to a wide range of interpretation and abuse. Some are extremely unlikely, cataclysmic or worst-case scenarios, designed to capture the attention of the mass media and the public and the support of those who control the purse strings in more developed countries. Others, the so-called denial scenarios, lead to inaction on the part of officials in charge and lull the public into a false sense of security. Caribbean islands that overlook their earthquake vulnerability by narrowly focusing on hurricanes are an example. Another, even more symptomatic example is persistent official denial of impending famine in the light of a major crop failure and food shortages. Obviously, the motivation and rationale in these two examples may be quite different.

### *Formulating a plan*

A disaster plan consists of two parts:

- *the main body* which assigns specific responsibilities, defines lines of authority and sets out administrative procedures for each probable or potential disaster scenario; and
- *the operational annexes* which list the resources available, the addresses of key personnel or suppliers and technical guidelines.

The first part of the plan will state who is responsible for water supply and quality control in temporary camps while the second part will list the addresses of chlorine manufacturers or experts and provide technical specifications for chlorination of water containers.

According to the resources available and the country's level of development, the plan can be limited to the most probable disaster situations or extended to cover less likely possibilities.

The process of formulating a disaster plan is perhaps more important than the final product itself — the written document. Finding advance solutions to the most common problems can be more beneficial than building extensive stockpiles of equipment. Potential problems can be organizational: for instance, who will coordinate medical triage and care at the disaster site — the hospital physician, the Red Cross, the fire department, the army medical officer, or can anyone and everyone fight for a piece of the action? Problems can also be institutional in nature. Disaster relief is not immune to interagency turf fighting and manoeuvring for visibility. Therefore, disaster plan-

ning becomes indispensable to resolve in advance as many potential conflicts as possible, thus minimizing the confusion that results from crisis situations.

Recruiting an “expert” to draw up a scientifically sound disaster plan or assigning the task to a deskbound planner is just not effective. Stories abound in the disaster relief community of sophisticated plans that merely gather dust on a shelf or are never consulted in times of emergency. The process of openly discussing an agency’s self-perceived role in an emergency, and its constraints and limitations is, in itself, a way to ensure better coordination among agencies. Latin America has used the process (or excuse?) of formulating a disaster plan to promote ongoing, productive discussion between ministries of health and social security, the armed forces health services and the Red Cross.

### ***Testing and updating the plan***

Simulations and mock disaster drills are needed to test the plan, not to show the mass media and the public how well prepared we claim to be. Testing will identify unforeseen flaws and weaknesses in the system. Any plan that claims to be 100% successful is a fake. On the contrary, the more problems that are detected (and corrected later), the better. Often, foreign experts are invited to participate in simulation exercises involving hospitals, the armed forces, municipalities and other institutions. Officially, their role is to assist in the “critical evaluation” of the exercise and the plan. But they quickly realize that constructive criticism is not welcome; the public relations display has little to do with improving the state of preparedness.

A final word: Do not forget that mock disasters are only a pale imitation of reality. Never be too complacent. A successful simulation is not a foolproof guarantee that the response to a disaster will be smooth.

### ***Training and public information***

As alluded to before, the response to a disaster rarely follows the neat contingency plan drawn up in the quiet environment of an office. The quality of the response will depend first on the readiness and qualifications of the first responders, local leaders and the primary health services in the affected communities and, second, on the ability



of the country's central authorities to support and coordinate the response from abroad. The better prepared the local health services and communities are, the better the overall national response will be. Developing human resources through training those who train should be an essential component of disaster preparedness.

The entire health services (primary, secondary and tertiary health care providers) respond to the health challenges of a disaster, and so do the Red Cross or the Red Crescent and the affected community itself. Consequently, everyone, from the man in the street to the general director of health services and higher, should benefit from disaster management training. It is a never-ending task.

Remember: Disasters are managed by people. Competent, well-informed volunteers or professionals are the key to a successful response, not money, supplies or equipment (though they admittedly help).

Experience in past disasters has confirmed that normal medical care, disease control, or environmental health measures are still the most appropriate in disaster situations. However, they must be implemented more rapidly, effectively and widely, with less resources, and under more difficult circumstances. It is not surprising, therefore, that improving health care in disasters is often contingent upon improving the quality and efficiency of health care in normal times. Training activities aimed at one will benefit the other.

It is at the *family and community level* that the most decisive and immediate post-disaster health actions take place. In sudden-impact disasters, search-and-rescue operations are carried out and initial care provided by relatives and neighbours rather than by organized health services or fire departments. At the family level, the most useful contribution may be the Red Cross/Red Crescent Society's efforts to promote basic first-aid training. Closer cooperation is required between WHO, the National Red Cross/Red Crescent Society and the Ministry of Public Health to ensure that first-aid training is given the necessary priority and support it requires. To be effective, local organizations and community leaders must be involved in disaster preparedness activities.

Despite their usefulness, *ad hoc* courses and workshops are not sufficient. In order to "institutionalize" emergency preparedness in the health sector, the educational curricula of academic or technical institutions that train the country's health personnel must progressively include the basic principles of emergency preparedness and disaster management. The systematic exposure of new generations of health professionals such as doctors, nurses or sanitary engineers to the basics

of emergency preparedness is vital to the stability and the continuity of the programme at the national level. Considerable success has been achieved in Latin America and Europe. In 1990, a survey among faculties of public health in Latin American universities revealed that more than 55% included disaster preparedness in the curriculum; of these, 64% had "formalized" the subject. In the long run, formal education should progressively replace basic disaster management workshops and training sessions.

## **Disaster prevention and mitigation**

Progressively throughout the 1980s, preparedness has improved significantly in many countries. In Latin America, for instance, thousands of professionals have been trained and the countries have designated full-time health coordinators to prepare and mobilize the health sector for disasters. In the Caribbean, the League of Red Cross and Red Crescent Societies worked jointly with UNDRO and PAHO/WHO in a decade-long disaster preparedness project. They have raised awareness and encouraged timely action in these island nations, thus ensuring that preparedness reaches a peak at the start of the annual hurricane season.

But disaster-related casualties are still high and the numbers are rising. Losses are not decreasing. Disasters and accidents remain a major obstacle to development and health. One more step must be taken to deal with the cause of the problem: prevention and mitigation.

A disaster need not have serious social or health-related consequences. The probability of a disaster occurring can be reduced by careful land use, by selecting proper sites for public works and by including or considering these factors in development planning.

Prevention and mitigation actually have the greatest potential for saving lives and reducing losses. But the scope of these measures goes far beyond the public sector, the medical community, or the Red Cross/Red Crescent system.

Certain prevention activities are directly relevant to the health sector. These include:

- early warning systems for drought and famine;
- location and design of health facilities;
- public education on house-building techniques.

### ***Early warning systems for drought***

The most visible and important effect of drought is widespread protein-energy malnutrition, which is definitely a health issue. Climatic, agricultural and market data make early detection of impending drought and food shortages possible. But the current collection of data and their analysis tend to rely heavily on sophisticated satellite and computer technology; this, in turn, depends on the funding and personnel from developed countries. But the already existing networks of epidemiologic surveillance, community health workers and Red Cross/Red Crescent volunteers could provide excellent support for collecting data at grassroots level and the opportunity to monitor the incidence of nutritional change.

### ***Location and design of health facilities***

The health sector is directly responsible for ensuring that new health facilities are built in safe places and that they adopt reasonable building norms and safety practices in areas that are prone to earthquakes, cyclones or floods. The complete destruction of hospitals — in Mexico City, El Salvador and Armenia — must be prevented in the future.

### ***Public education in building techniques***

Following earthquakes, cyclones and other sudden-impact natural disasters, the majority of casualties results from the collapse of unsafe housing structures.

Red Cross/Red Crescent volunteers should cooperate very closely with the ministries responsible for housing and, together with health professionals, they should actively disseminate knowledge and information about low-cost techniques that improve the disaster resistance of local building materials.

Reducing the human toll of natural or technological disasters requires a change in attitudes, from the head of State to the head of family. We are already slowly adjusting the way we build cities or manage agricultural land in order to reduce the risk of global pollution. We should now promote the same type of thinking when it comes to making public constructions or housing more resistant to natural hazards. Are the local hospital, the Red Cross/Red Crescent

Society's headquarters and its warehouse reasonably protected from major disasters? This is not the exclusive domain of some higher authority, it is everyone's concern and responsibility.

At the community level, the Red Cross or the Red Crescent, UN agencies and governments have initiated several pilot projects. For instance, the Italian Cooperation has tested and applied a procedure whereby small, poor communities are encouraged to identify local risks, discuss local solutions and implement them. The message is that disaster prevention should not be limited to that one giant cyclone or the earthquake of the century. Small disasters that occur in modest communities probably kill more people than the highly-visible events that attract international attention. Those small landslides, fires and chemical accidents may represent a custom-made challenge for organizations such as the Red Cross/Red Crescent Societies with their strong roots at the community level.

Disaster reduction, from prevention to response, is the objective that the international community has selected for the 1990s. All Member States of the United Nations have formally adopted the International Decade for Natural Disaster Reduction (IDNDR). Countries are urged to establish a high-level national IDNDR committee, where public officials, the private sector, NGOs, scientists and other leaders will join forces to mobilize public opinion and the country's resources for a national programme.

With their considerable experience in the social field, health workers, including the Red Cross/Red Crescent Societies, are particularly well placed to play a key role in this undertaking.

## **Disaster Reduction and Relief**

Prevention and mitigation *will* reduce the impact of disasters on health, but this will take time. On the other hand, they *will not* make society invulnerable. Buildings will continue to collapse — both older, unsafe ones and newer ones that are subjected to forces above and beyond those they were designed to withstand. Nor will prevention and mitigation suppress the need for humanitarian assistance and international solidarity. The process of providing external assistance will, however, have to undergo changes in the coming years, especially in developing countries with sophisticated health systems. There is neither justification nor room for the international dumping of expired drugs, used clothing or perishable foods.

Well-intentioned foreign medical volunteer teams or mobile hospitals that arrive the second or third day do little to save lives after sudden-impact disasters. The task has been completed by the nationals long before!

Developing and promoting a well-advertised search-and-rescue capacity in *developed* countries should not sidetrack the international community from the more important need to develop this on-site capability in disaster-prone developing countries. Unfortunately, transfer of technology and training are definitely less attractive than a highly-publicized, post-impact international response.

Do present trends in international relief complement and support preparedness and response efforts or do they, on the contrary, compete with or even supplant them? There is no clear-cut answer. Definitely, international relief assistance needs to be better attuned to development and disaster-reduction activities. Too much international attention is given to immediate needs in the aftermath of a disaster, and too little to the secondary problems. The immediate needs—search and rescue, medical care, shelter and food—can be dealt with promptly and effectively only by well-prepared local health workers or volunteers.

Relief, preparedness and prevention/mitigation are closely interdependent. Health relief assistance in the 1990s will have to become an integral part of development if it is to play its role in meeting the goals of the International Decade for Natural Disaster Reduction.

**Dr. Claude de Ville de Goyet**

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# Community-based health care in disasters

by Dr. Bruce Dick

## Introduction: disasters and health for all

“Health for All by the Year 2000” has been a major goal, an important rallying cry for individuals and organizations around the world concerned about improving the physical, mental and social well-being of vulnerable people. Of course it has been a somewhat idealistic goal, as has the World Health Organization’s definition of health. However, it has served a useful function, both in terms of what it says positively about our vision for the future and also by reminding us, implicitly if not explicitly, that for many hundreds of millions of people the reality is still very far from the dream.

Of course, at the same time that many of us are working towards the attainment of the Health for All goal, there are a number of forces which work in exactly the opposite direction. National debt repayments, structural adjustments, continuing expenditure on armaments, the pushing of infant formulas and inappropriate medicines, cigarettes, alcohol and other drugs, all negatively affect the progress that is being made.

There are also other factors which are often even less under our control, that continue to undermine our efforts, and the most notable among these are disasters. Many disasters are increasing, or at least their impact is, due to technological “progress”, environmental degradation, population growth and the power of micro-organisms to outwit our schemes to control them.

## Disasters and community-based health care

The main strategy to achieve the goal of Health for All by the Year 2000 has been primary health care (PHC), with its emphasis on prevention, equity and appropriateness, and with the priority that it

places on different sectors working together and on community participation. This latter aspect of PHC has, for a number of reasons, been the most difficult to transpose from the planning and policy documents into action in the real world.

Over the years, non-governmental organizations (NGOs) have identified the lack of real community participation as a major obstacle to the Health for All goal. They have therefore put a great deal of effort into exploring different ways of really working with communities, ways of identifying and prioritizing the problems with them (“their” problems, not “ours”), exploring solutions to these problems with the communities concerned, and strengthening the communities’ resources in order to empower them to meet the priority problems that they have identified.

Again the ideal has often been difficult and time-consuming to achieve—none of us are particularly used to working in this way. However, through such an approach we have managed to avoid many of the problems that programmes planned from the outside have encountered in the past. The League of Red Cross and Red Crescent Societies has committed itself to PHC through resolutions adopted by the General Assembly in 1981 and 1986. In addition, it has focused on the development of community-based health programmes and has emphasised the need to strengthen such an approach in its Strategic Work Plan for the Nineties.

## **Disasters: who is affected and what are their health problems?**

During the 1980s it became increasingly clear that despite all the social, economic, technological and infrastructural progress made, many individuals, families and communities remained untouched by the developments that have taken place. The most vulnerable people will differ from country to country, and even within countries from district to district. However, certain groups will be common to most situations, including people living in extreme poverty, women, children, the disabled, the people who suffer from discrimination, and single-parent families. People who are affected by disasters are also particularly vulnerable and, ironically, the groups who are most vulnerable on a daily basis are, in general, also most seriously affected by disasters.

Most of us have an intuitive understanding of what a disaster is. There are, however, a number of more formalized definitions. These vary depending on the sector and the perspective, but most of them include some concept of change, often sudden, and the idea that the affected people's capacity to cope becomes overwhelmed, at least temporarily. Of course we can broaden our concept of disasters to add many of the daily disasters to the list of media-intensive ones. The millions of deaths from diarrhoea and the vaccine-preventable diseases have been called the silent emergencies, or hidden disasters, and certainly AIDS, malaria and other endemic debilitating diseases are on-going disasters for many communities.

It is of course these very problems that are exacerbated by disasters, since disasters generally do not give rise to new diseases but merely increase the load of the common diseases that are related to poverty, lack of clean water and food, and the absence of basic medical care.

## **Disasters: how do they differ from “normal” times?**

It is very questionable how useful the traditional ways of classifying disasters are, particularly when it comes to thinking about response. The “natural/man-made” divide is extremely difficult for most disasters since the two are so interrelated. If we take the example of a flood, is this natural (after all the rain is natural enough) or man-made (the people affected are living in high-risk areas only because they are poor and because of population growth, and the flood has occurred only because of deforestation)?

Another way to classify disasters is “sudden impact/slow onset”. This is also not particularly useful since we may need a rapid response to slow-onset disasters if the warning signs have been ignored, and we may need to concern ourselves primarily with the rehabilitation phase of sudden impact disasters if the community response to the immediate effects has been adequate.

Since disasters are only disasters if there are people around to be affected by them, directly or indirectly, classifications focusing on the people, the communities affected, or the problems that were caused, both immediately and in the long term, would be more useful when it comes to thinking about what needs to be done, when and for/with whom.



In general the groups most seriously affected by high-visibility disasters are the same as those affected by life's daily disasters. The diseases that they suffer from are also much the same in disaster and non-disaster times, although some disasters, such as technological disasters, Bhopal and Chernobyl for example, and earthquakes may give rise to a new set of health problems.

In addition to the physical health problems, a recent Red Cross and Red Crescent Consultation on the psychological impact of disasters emphasized that the risk factors and psychological needs are much the same following disasters as they are following other stressful life events, such as the death of a loved one, or the loss of one's job.

Another important similarity between disasters and normal times is the community response. Following disasters, it is the local community members who give food to the newly arrived displaced populations, who pull people out of collapsed buildings, who give shelter and clothes to the people whose possessions have been washed away in the flood. They may not get as much media time as the outsiders with their sniffer dogs and infra-red cameras, or the expatriate medical teams with their aluminium trunks and their logos, but they do what needs to be done none the less.

A community-based response to disasters is not a new idea, it is what happens (contrary to popular belief, disaster-affected communities are not passive and apathetic). What might be new, however, is the idea that we should be putting our resources into reinforcing the community's capacity to respond, both before and after the event.

Finally, while there is a need for a rapid response to the so-called silent emergencies, in the case of disasters this need is often even more acute. For some disasters there must be a response within the first 24 hours (long before the medical teams fly in), for example search and rescue operations after earthquakes. For others, the major unmet needs will surface only during the rehabilitation phase (long after many of the teams have flown out). However, for almost all disasters, the most important time to act is *before* they occur, in the form of disaster preparedness.

## **What needs to be done — principles**

It is becoming increasingly clear that our response to the health problems caused by disasters will need to be based on the PHC approaches and infrastructures that have been developed to respond to everyday health problems. This makes good theoretical sense since the

vulnerable groups, the health problems and the need for a community-based approach are common to both. It also makes good practical sense, since in the same way that it is the already vulnerable people who are most vulnerable to disasters, so it is with countries. It is inconceivable that poor countries which cannot even cope with the daily disasters that confront them will be able to develop a separate system for responding to the high-visibility disasters (which receive great media attention but which in general cause a very small percentage of the daily toll of disease, disability and death).

Of course there will have to be central planning and a national programme, just as such things exist for the daily emergencies of diarrhoea, vaccine-preventable diseases, malaria, acute respiratory infections or AIDS. But at district level our response will, as with all other health problems, rely on the local community.

Not only should disaster preparedness and response be integrated, but there also needs to be a focus on the national and local level response. Whilst some aspects of international response will often be necessary, focusing on the national and local levels will help to contribute to sustainable development, something that the disasters themselves will tend to undermine. There also needs to be a much greater emphasis on supporting national capacity to coordinate the response, both centrally and at local level, if the agency anarchy of the past is to be avoided in the future.

## **What needs to be done — practice**

National Red Cross and Red Crescent Societies are obviously in a very good position to make an important contribution to coordination at national and local levels, as was seen recently in the response to the Kurdish refugee problem in Iran and Turkey. It is to be hoped that with the support of the League and their respective governments this role will be strengthened and that this in turn will help to focus on strengthening a community-based response.

National Societies are also in a very good position to give a lead on the issue of integration. Many have already demonstrated that their long-term programmes develop skills and activities that can contribute to disaster response. For example, the volunteers of the Indian Red Cross's Child Alive programme have responded to outbreaks of cholera, and it is to be hoped that a similar response will be possible from the Child Alive programmes in Central America to the cholera pandemic in this region. Similarly, the Philippine National Red Cross

community-based Barangay Health Workers were able to respond to the problems of the people affected by the earthquake in the Philippines in 1990.

Refugees often pose different problems, and for a number of reasons, from government policy to social disorganization within the "community", it may sometimes be difficult to base the response on the community. However, this should be the aim, and it is certainly the optimal option, at least in the longer term. Expatriate health teams will often continue to be needed, but their focus should be on training the refugees themselves to deal with basic health problems in terms of the prevention and home management of common diseases, something that has been taking place in the Pakistan Red Crescent's health programme for Afghan refugees.

Although refugees may present an extreme case, even under less difficult conditions community participation is likely to be difficult and time-consuming, for a number of reasons. These range from the fact that communities are often much less homogeneous or cohesive than the ideal community that features in the planning documents, through the myth that community participation is a quick or cheap option, to the fact that many governments would like people to do the work but are often less keen for them to have a major role in deciding about problems and priorities.

It is clear that even within the Federation there is a wide diversity of opinion about the meaning of "community-based health programmes". For many it describes those health activities that are carried out in the community rather than in a hospital or a clinic. However, such a definition clearly falls far short of effective community participation.

To emphasize the need for a community-based health approach to disasters should not, of course, be seen as implying that there is no need for external assistance, either from within the country or internationally. Many of the definitions of the word "disaster" include the concept of the community being unable to cope using its own resources. There will often be a need for food, for shelter materials, for medicines and for technical advice and support.

However, what the community-based approach does emphasize is the need to listen to and involve the people affected in the decisions that are taken about what needs to be done and for whom, and in their implementation. It means listening to the community when it comes to decisions about vulnerable groups, food distribution, water and sanitation. It also has important implications for disaster preparedness.

## **Disaster preparedness — a priority for community-based response**

Disaster preparedness involves much more than physical structures. It means identifying relevant activities, developing the necessary skills to carry out these activities, and ensuring that there is an organizational capacity and an appropriate political environment in which what needs to be done can be done — these were the lessons of Henry Dunant, and they apply as much today as they did 130 years ago.

Whilst there will be a continuing need for the political environment and attitudes to develop and move with the times (a current example is the debate about the right to act, internationally, on humanitarian grounds), there is still a great need for politicians and policy makers to fully appreciate the need for disaster preparedness, and the need for it to be community-based.

National Societies have a number of ways to contribute to a community-based response to disasters, as was emphasized at the League's Consultation on the health aspects of the International Decade for Natural Disaster Reduction. First, they can develop and strengthen their existing community-based health programmes and ensure that these are able to respond in times of disaster as well as in normal times. Several examples of this have already been mentioned. It is perhaps interesting to note that community-based health programmes may also develop out of disaster response, as for example in Sudan and Ethiopia, and disaster preparedness programmes may themselves provide opportunities for community-based development, for example the Bangladesh Red Crescent's cyclone shelter programme.

The second possibility is community-based first aid. First aid has grown from a variety of influences, from Christian charity, by way of Florence Nightingale and the Countess of Gasparin, to Henry Dunant. Although for some people first aid has retained a very narrow meaning, namely the stabilization and transport of people on the battlefield under the protection of the emblem, for most National Societies first aid has evolved into something much broader and more relevant to a range of emergency situations.

In essence, over the years, National Societies have done two things with their first aid programmes. Some have used their battlefield skills to respond to other disasters where these skills would be appropriate, for example earthquakes, or to other emergencies, for example accidents on the roads in the mountains or in factories.

Others have expanded their first aid programmes to include skills which would help volunteers respond to the common emergencies in their communities, and the health problems resulting from the common community disasters, for example the home management of diarrhoea. Many have also been influenced by primary health care and have added elements of prevention to their programmes.

Patrick Couteau, in his review of first aid in francophone West Africa, discovered, amongst other things, that although many thousands of first aiders were trained by the National Societies in the region, the National Societies very quickly lost touch with the people they had trained. One of the main reasons for this was that the skills the first aiders learnt bore little relation to the types of problems that they encountered, either in their daily lives or following the common disasters that affected the communities with whom they lived and worked.

The League is currently building on the findings of this study and a number of regional workshops that have been held, in Africa, the Pacific and the Caribbean, to identify ways of strengthening and developing first aid programmes in the Federation. First aid is the major training programme of the majority of Red Cross and Red Crescent Societies and our most unifying health activity. There is a growing feeling that they could also contribute more appropriately and effectively to dissemination, to disaster preparedness, and to providing a community-based response that would meet the sudden and the daily emergencies that surround vulnerable individuals, families and communities.

In our attempts to simplify a complicated reality, there has been a tendency to separate disasters and emergencies from the everyday problems that confront vulnerable people. While this may make bureaucratic sense, it does not necessarily help our understanding of the problems. It also does not always contribute positively to our response, particularly those aspects of the response that must come before the relief effort, namely prevention, early warning, mitigation and preparedness, and the rehabilitation and recovery that must take place afterwards.

For most disasters, since the vulnerable groups and the health problems are much the same as in normal times, we need a more integrated approach. We also need to learn from the lessons of responding to the daily disasters that surround vulnerable people, which we call development. Of all the lessons that we have learnt, one of the most important is the need for a community-based approach. The more we can apply this to our disaster response activities, the more effective we

will be, and the more we will contribute not only to preventing and alleviating the suffering caused by high-visibility disasters but also to the sustainable development that will counteract the impact of daily disasters.

**Dr. Bruce Dick**

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**Bruce Dick, M.B., D.C.M., M.F.C.M.,** qualified from Guys Hospital, London, in 1971, and intended to become a paediatrician. However, his experience of clinical paediatrics in South Africa moved him into specializing in Community Medicine at the University of Cape Town. He worked as an academic and then as a district medical officer in a rural hospital in South Africa. He returned to England in 1980 where he worked as a community physician in the National Health Service, during which time he became a member of the Faculty of Community Medicine, and as a research fellow in the Evaluation and Planning Centre of the London School of Hygiene and Tropical Medicine. For the past five years he has been Head of the Health Department of the League of Red Cross and Red Crescent Societies.

## **DEATH OF ALEXANDRE HAY**

Former ICRC President Alexandre Hay died on 23 August in Geneva at the age of 72. With Mr. Hay's passing the International Red Cross and Red Crescent Movement has lost a true champion of the humanitarian cause, wholly committed to upholding the law and the Movement's ideals and to promoting peace through dialogue.

Mr. Hay was born in 1919. He was educated in Geneva and qualified as a lawyer in 1944. In 1945 he joined the Swiss Federal Political Department in Bern. After serving from 1948 to 1953 as Secretary at the Swiss Legation in Paris, he was appointed director of the international relations division of the Swiss National Bank in Zurich. In 1955 he moved to the Bank's headquarters in Bern, where he became Director-General in 1966 and later Vice-President, a post he occupied until 1976.

Mr. Hay joined the International Committee of the Red Cross in 1975, and the following year became its eleventh President, a position he held for nearly 11 years. After stepping down from the Presidency in 1987, he continued rendering invaluable services to the Movement in his capacity as Chairman of the Commission on the Red Cross, Red Crescent and Peace and as President of the World Campaign for the Protection of Victims of War.

The unprecedented expansion of the ICRC during Alexandre Hay's decade in office — a decade marked by innumerable crises<sup>1</sup> — bears witness to his profound attachment to human values, his dedication, his overwhelming generosity and his leadership qualities. Sound judgement and compelling sincerity were among Mr. Hay's most outstanding attributes. He never compromised on matters of principle and showed remarkable courage and clearheadedness in campaigning for greater humanity in the world.

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<sup>1</sup> See "Under the Presidency of Mr. Alexandre Hay: the ICRC from 1976 to 1987 — Controlled expansion", *International Review of the Red Cross*, No. 261, November-December 1987, pp. 621-638.





A memorial service was held on 30 August in St. Peter's Cathedral in Geneva. A large congregation, including the members of the ICRC Assembly and Executive Board and many of the staff, representatives of National Red Cross and Red Crescent Societies and their federation, the League, and representatives of the Swiss federal and cantonal authorities, attended the service and heard the moving tribute paid to his predecessor by ICRC President Cornelio Sommaruga. The *Review* would like to share this tribute with its readers.

*The Review*

## **Tribute to Alexandre Hay**

*Alexandre Hay bore the last few months of his illness, which he knew was extremely grave, with lucidity and fortitude. He had full confidence in his doctors but as a deeply religious man he knew that, while our duty as human beings is to strive for success in what we do, the final word lies with the Creator. He never made a show of his religious conviction, but at the hour of reckoning did not hesitate to affirm his unreserved submission to God's will.*

*Mr. Hay and his family remained confident right up to 23 August, and we all shared their confidence, hoping against hope. Alas, our hopes were in vain and we had to face grim reality. Everyone at the ICRC and all his friends in the Red Cross and Red Crescent Movement were deeply shocked and saddened, sharing the pain felt by his family and particularly by Mrs. Hay, who had surrounded her husband with loving care from the onset of his illness.*

*In the days that followed we slowly began to measure our loss. Alexandre Hay, with his warm and generous personality, is no longer with us. Little by little, however, grief is giving way to thoughts about the course his life had taken, about all he gave us and the Red Cross as a whole, and about all he did to alleviate the suffering of so many victims of conflict throughout the world.*

*We recall things we already knew, but which we now perceive with renewed admiration. How could this artistically gifted man move with so much ease, and without sacrificing any of his inclinations or basic convictions, from law to diplomacy, from diplomacy to finance, and*

*from finance to humanitarian work, achieving the most outstanding results of his career through his dedication to the Red Cross mission?*

*It would be wrong to say that he had his “secret”, because although a man of considerable discretion Alexandre Hay was never secretive. He was loved and respected by all, and whatever he did was done in the firm belief that everyone around him, both within and outside the ICRC and at all levels of the hierarchy, was a fellow individual and that all staff members had a mission to fulfil and should join forces to serve others. One of his great natural gifts was his sense of service, founded on consideration for others and prompted by an acute sense of justice and a discreet but deep feeling of charity.*

*Mr. Hay’s awareness of his responsibilities as President was coupled with the intimate conviction that his primary duty was to serve — to serve everyone. His first concern was to listen to those around him, as if better understanding were the key to providing better service. He rarely voiced an opinion until he had heard what others had to say, and when he did so, he spoke in simple and measured terms, preferring a quiet statement of facts to flights of rhetoric. Everyone knew that his words were prompted by sound judgement and consequently they always rang true. Indeed, he had a natural authority which made him an effective and exceptional leader of men.*

*Alexandre Hay’s discretion, sense of service, respect for others and simple and direct language made him a perfect “Red Cross person”. His statements always included a reference to the fundamental principles of humanity, independence, neutrality and impartiality, and they became the basic tenets of his daily existence. He came to the ICRC after many years with the Swiss National Bank in Bern, and adjusted remarkably quickly to the requirements of the humanitarian mission, maintaining the independence he had so successfully achieved at the Bank. He enjoyed the art of humanitarian negotiation and knew how to capture his audience’s attention and win the confidence of his counterparts at the highest level, whether in government, international organizations or opposition groups of all sorts. Suaviter in modo, fortiter in re might have been his motto.*

*His thoughts, beyond any legal, diplomatic or political considerations, were always directed to the ultimate objective of the Red Cross, handed down by its founders — humanity. And if, in the heat of action, one of his colleagues appeared to forget that fundamental principle, President Hay always gently but firmly brought him back onto the right track. Although he was faced daily with poverty, despair and the cruelty of war, Alexandre Hay drew strength and serenity*

*from his profoundly humanistic and humanitarian beliefs and an optimism that naturally spread to all those around him.*

*President Hay's skill in humanitarian negotiation opened many doors to the ICRC. His primary concern was to gain access to the victims of conflict, to all those entitled to receive protection and assistance from ICRC delegates. But negotiations are also called for in financial matters. His talent as a financier and organizer and the personal relations built up over years of economic and monetary diplomacy had well prepared him for the task. His insistence on strict control over the institution's finances, his generosity of spirit and persuasiveness made him a staunch defender of the ICRC's financial interests vis-à-vis States, National Societies, governmental organizations, NGOs and private donors. Thanks to the remarkable results he achieved, ICRC activities saw a considerable expansion in a world that had an ever-growing need for a neutral humanitarian intermediary.*

*Development, dissemination and implementation of international humanitarian law were also among President Hay's major preoccupations. He was convinced that the ICRC's operational expansion should not take precedence over the institution's historical and moral responsibilities and treaty obligations with regard to the law. In legal as well as financial matters he maintained a policy of openness and mutual trust with the Swiss Federal Council, Parliament and Administration in Bern. I myself was working in the Swiss capital at the time and on many occasions remarked the high esteem in which he was held, in recognition of his courage in rising to the great humanitarian challenges of our time.*

*In his speeches and lectures he always came back to the same idea of a humanitarian mobilization based on the Red Cross principles. The spirit of Geneva pervaded the life of this true citizen of Geneva, proud to be at the head of the venerable institution to which his city had given birth.*

*The International Red Cross and Red Crescent Movement and its unity was one the great causes embraced by President Hay up to the very end of his life. He constantly sought dialogue with his colleagues at the League and in the National Societies. He was concerned about certain problems of communication, feared politicization of the Red Cross world and insisted that within the dynamics of the Movement's development the ICRC must maintain its role as a specifically neutral institution discharging its own special mandate with the support and cooperation of the National Societies. His firm stand on matters pertaining to the Movement's unity, his commitment to upholding the*

*Fundamental Red Cross and Red Crescent Principles, the interest he took in the development of National Red Cross and Red Crescent Societies, practically all of which he had visited in person, his profound belief in the principle of voluntary service and his sensitive approach to women's issues within Red Cross and Red Crescent organizations earned him the respect and admiration — and often the friendship — of those he met throughout the Movement.*

*The presence here today of so many distinguished personalities from the Red Cross world bears witness to the high regard in which President Hay was held by all. The messages of sympathy that have poured in from colleagues and friends the world over testify to the resounding success of President Hay's tireless work in behalf of the ICRC and its humanitarian goals and pay tribute to his achievements in the service of the noble objectives of peace and justice, which he pursued with such remarkable determination, wisdom and efficiency.*

*True to the motto per humanitatem ad pacem, after stepping down from the Presidency Alexandre Hay centred his efforts on the promotion of peace. When I took over from him in May 1987 and he addressed the ICRC Assembly in his capacity as Chairman of the Commission on the Red Cross, Red Crescent and Peace, he stressed that he intended the Commission's work to focus on the action to be taken among young people and in the area of information so as to enhance public awareness of the Red Cross's contribution to peace. The next logical step for him was to assume the presidency of the World Campaign for the Protection of Victims of War. This was his last effective contribution to Red Cross work. Despite very poor health, he attended the concert held on 8 May in the Avenue de la Paix and was thus able to see this major undertaking through to the end.*

*Alexandre Hay was not only a man of action but also an extremely sensitive and kind-hearted person. He did not sit in judgment on others or tell anyone what to do. But what he did and what he was served as a wonderful example of courage, humanity, trust and loyalty to an ideal of human compassion. When such a charismatic figure passes away, whatever his age, it is always too soon for those who remain.*

*The grief felt by his wife and family is shared by everyone who knew Alexandre Hay and by all those who aspire to greater justice and respect for human rights. The entire Red Cross and Red Crescent Movement and the ICRC in particular, the institution's current and former staff members and I myself — who enjoyed his support and*

*invaluable counsel when I succeeded him as President — owe Mr. Hay an immense debt of gratitude.*

*The city of Geneva and all Switzerland, the entire international community and victims of conflict throughout the world join with us in expressing our admiration for this great servant of humanity. The memory of his extraordinary personality will live on with us always.*

**Cornelio Sommaruga**  
*President*  
*International Committee*  
*of the Red Cross*

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## IN THE WORDS OF ALEXANDRE HAY...

### Red Cross, Red Crescent

“It may be, indeed, that the strength of the Red Cross lies in the limits it has set for itself. It does not lay claim to any abstract truth, except that suffering human beings are deserving of help by the very fact of that suffering”.

*Address by the President of the ICRC on the occasion of the visit of His Holiness Pope John Paul II, on 15 June 1982*

“We are now engaged in a ‘planetary Solferino’. For every member of the Red Cross and the Red Crescent, all the victims of the current Solferino represent a personal challenge, especially those far too numerous victims to whom we have no access.

We feel solidarity with the victims of all conflicts, just as we feel solidarity with the members of National Societies and the ICRC delegates who bring them assistance and protection. Like Henry Dunant, we should know that we must act and look ahead into the future”.

*Opening message to the Second World Red Cross and Red Crescent Conference on Peace (Aaland/Stockholm, September 1984)*

“In this world riddled with every form of violence, unspeakable misery and perpetual tension and conflict, the work of the ICRC remains indispensable. Although this task is difficult and hampered by countless obstacles, it remains a noble one, well worth being pursued with courage and conviction”.

*Assembly of the ICRC (6 May 1987)*

## **Respect for international humanitarian law and State responsibility**

“How many governments are there which have still not understood that, in the long term, humanitarian problems are remorseless in their effects on those who ignore them?”

*Opening message to the Second World Red Cross  
and Red Crescent Conference on Peace  
(Aaland/Stockholm, September 1984)*

“It is not always easy to persuade States in conflict to maintain a balance between humanitarian imperatives and their security requirements. It is even more difficult to convince States that their security would be improved if they granted victims of the conflict who are *hors de combat* the protection to which they are entitled under international humanitarian law”.

*Respect for international humanitarian law —  
Twenty-fifth International Conference of the Red Cross  
(Geneva, October 1986)*

## **Humanitarian mobilization**

“Even where the formal application of law is contested, humanitarian principles must prevail, the essential values of humanity must be respected at all times. The first of these is recognizing the spark of humanity in all men (...). The protection of humanitarian values must be one of the priorities of States and of every man, and part of a collective strategy; it must be included in negotiations and international agreements and have the support of the public conscience”.

*Ibid.*

## **Peace**

“It is through our personal commitment in the fight against disease and underdevelopment, through our ceaseless struggle for the dignity of man, for respect for the rules of humanity and through the gesture intended to help, protect and save, repeated a thousand times every day and over the whole planet, that the Red Cross remains the world’s most forceful movement for the humanitarian ideal of peace”.

*Opening message to the Second World Red Cross  
and Red Crescent Conference on Peace  
(Aaland/Stockholm, September 1984)*

### **Preparing for the 26th International Conference of the Red Cross and Red Crescent**

*The Hungarian Red Cross will host the 26th International Conference of the Red Cross and Red Crescent to be held in Budapest in November/December 1991.*

*The representatives of States party to the Geneva Conventions and of the components of the International Red Cross and Red Crescent Movement attending the Conference will be invited to discuss such key issues as respect for international humanitarian law (IHL) and the activities of the ICRC; the implementation, promotion and development of IHL; development; Red Cross and Red Crescent response to natural and technological disasters and the problem of refugees.*

*The Review will devote its January-February 1992 issue to the proceedings and conclusions of the Conference and other statutory meetings of the Movement. We have the pleasure to publish an article by Mr. **Rezso Sztuchlik**, President of the Executive Committee and Secretary General of the Hungarian Red Cross, who has been kind enough to express his thoughts on major topics of the Conference and on the new challenges facing his National Society.*

The Hungarian Red Cross is greatly honoured to have been chosen as the host for the 26th International Conference. It is the first time, during the Society's 110 years in existence, that the Conference is being organized in Budapest. What does it represent for us, and what do we expect of it?

First of all we would like to offer to all our Red Cross and Red Crescent friends such hospitality and working conditions that they will be able to make good use of this opportunity for the further development of our worldwide humanitarian Movement. We are confident that, with many parts of central and eastern Europe in turmoil, the conditions of stability in Hungary will help delegates in this undertaking. The events of recent years and months justify a thorough analysis of our action and the conditions in which we work. Let me share some of our concerns with you.



## The world environment

We have to recognize that in our world of today, despite the development of international political and legal instruments and institutions aimed at ensuring that political, economic, ethnic, religious and other tensions and disputes are dealt with through bilateral and multilateral negotiation, there is a continuing tendency to resort to violence in an attempt to “settle” internal and international conflict situations. This confirms what the Tansley Report suggested back in 1975, i.e. that the world may have crossed the boundary into a state of permanent emergency, bringing with it increased vulnerability and instability. Tansley’s conclusions were that:

1. disasters are likely to occur with more frequency and with greater impact;
2. new types of disasters may be expected; and
3. conflict situations are likely to increase.<sup>1</sup>

As I pointed out in a study written jointly with Anja Toivola, this forecast proved correct. Recent and current events confirm it even more. The easing of global tensions, the phasing out of the cold war may lead to individuals and groups standing up more firmly for their rights, tolerating authoritarian regimes to a lesser degree, and lead therefore to an increase in internal tensions and conflicts.<sup>2</sup>

On the one hand we can welcome with justified sympathy the fact that in significant parts of the world changes toward democratic institutions and legality are writing a new chapter in contemporary history, and also offer more freedom of action for our Movement to act according to our principles in these territories. On the other hand many (suppressed) tensions are now coming to the surface and creating new challenges for our humanitarian commitment, often outside the scope of classic emergency situations. Let us keep in mind that tradition is one of the strengths of our Movement when it urges us to use past experiences and a sense of humanitarian initiative in determining current and future tasks and roles, but it can be a disadvantage if it is lived through as an obstacle to adapting to changing situations.

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<sup>1</sup> D. Tansley: *Final Report: An Agenda for Red Cross*, Geneva, 1985, pp. 55-58.

<sup>2</sup> R. Sztuchlik and A. Toivola, *What was the impact of the Tansley Report?*, Henry Dunant Institute, Geneva, 1988, p. 18.

## Major topics and issues at stake

As for the issues to be discussed, it is of course not possible to comment on all of them. May I therefore only mention those which I see as the most urgent today.

One is the possibility for our Movement to be able to act whenever its intervention is required under the Geneva Conventions, and the role of the various components of our Movement as laid down in its Statutes. An important part of the responsibility here lies with the governments, i.e. to accept and respect the fact that access for the Red Cross/Red Crescent to the victims can under no circumstances be subject to political bargaining and reciprocity.

The second is to decide on the means for an expansion of our capacity of action in the nineties, especially in areas where there is a clear link between basic human rights and our humanitarian commitments. I consider as part of these questions the problem of torture, refugees, the individual and collective rights of ethnic, religious and other minorities, and women's rights.

As for the capacity of our Movement to fulfil its role as a unique humanitarian organization with a special status, we cannot be complacent and should admit that whether we shall or shall not be in a position to face the increasing need for humanitarian services in our times will largely depend on our ability and determination to better harmonize and utilize our common resources. At all levels and in all of our Red Cross/Red Crescent bodies, we should be aware of ourselves as being part of our worldwide Movement that has been able to identify with and act according to universally shared values and principles for well over a century, and this awareness should be reflected more strongly in our behaviour. Our Fundamental Principles should be seen as an everyday guide in all we do. We have to find the means, and I hope the *Strategy for the Nineties* will help in this, of joining our efforts at local, national and international levels in order to be more efficient both in conflict situations and in peacetime activities.

A painful experience in recent times has been the misuse of and/or lack of respect for our emblem. We ourselves have been confronted with such misuse during some of the operations in which our National Society was involved, and we would find support from the Red Cross/Red Crescent community extremely valuable in backing up our efforts to prevent it.

## Priorities for Red Cross action in Hungary

The Hungarian Red Cross wishes to be a reliable and constructive partner in the processes and programmes outlined above, guided solely by our independent humanitarian commitment. This international Red Cross/Red Crescent

solidarity also gives us strength to better perform our mission in Hungary. Over the last two years, the political changes that have taken place have presented new challenges to our Society, not only in taking up programmes corresponding to the most urgent needs, but also in building stronger credibility for our services and asserting and strengthening our position as an independent National Society. This we are doing in a rapidly changing political situation where everything that existed under the past regime has naturally been questioned, and where many erstwhile organizations have disappeared. We decided to concentrate on the services we were to offer to the population, to use the newly acquired political freedoms to initiate new programmes, especially social assistance programmes to help the poor and the needy, and thus, in addition to offering better services, also to strengthen our credibility in public opinion. At the same time, while being ready to intensify our co-operation with any humanitarian, religious, political or other organizations within the limits of the Red Cross Principles, we have avoided any move to be seen as politically pro-government or pro-opposition. As a result the various political forces present have also accepted us as an independent humanitarian organization, specialized in its field and endorsed by a decision of parliament which reconfirmed the validity of the special law governing our Society.

A I mentioned above, it was especially in the area of social assistance to the poor and the needy that we have had to improve our services. We have opened free-meal services, which now provide more than 2,000 needy people with free hot meals daily. We have set up aid programmes (food and clothing) which were well received by the public. The value of these programmes is shown by the fact that many are now co-financed by local authorities and for many of them we can find corporate and/or individual sponsors.

Our refugee assistance work has been another major task. Started back in 1987 with refugees from Romania, it continued with refugees from the Middle East, then from the former German Democratic Republic, Czechoslovakia, and the Soviet Union, and currently from Yugoslavia. In all over 30,000 refugees have received Hungarian Red Cross assistance over the past four years.

Until 1989 half of our financial resources were raised by ourselves, the other half consisting of government subsidies. Now, two thirds are raised by us, whilst one third is a subsidy voted by parliament and is therefore exempt from any risk of political influence. A traditional activity in which we have maintained our position is the recruitment of blood donors; despite worsening conditions (more needy and unemployed people), we have managed to stabilize the number of donors, which is quite good by international standards (52 per 1,000).

As for our structure, in June 1990 we decided to decentralize our organization so that decisions would be made where the problems really arise. This decentralization has freed new energies and increased the sense of humanitarian initiative and responsibility within our local branches. A continuing weakness is the insufficient number of trained volunteers, the inability of some of our staff to use fully the new possibilities of development and their recently acquired wider powers and, despite the progress we have made, the still inadequate level of disaster preparedness.

I hope that I have thus been able to give you an insight into our situation, programmes and present concerns. We shall receive you in Hungary with an open mind, feeling confident that with a true Red Cross/Red Crescent spirit we shall be able to prepare our Movement for the formidable challenges of the nineties. Welcome to Budapest 1991.

**Rezso Sztuchlik**

*President of the Executive Committee  
and Secretary General  
Hungarian Red Cross*

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## Unification of the German Red Cross and of the Yemen Red Crescent Society

CIRCULAR 556

Geneva, 1 July 1991

*To the Central Committees of the National  
Red Cross and Red Crescent Societies*

LADIES AND GENTLEMEN,

We have the honour to announce that the International Committee of the Red Cross, at its meeting of 1 May 1991, took formal note of the reunification of the German Red Cross.

The **German Red Cross** was officially reunified on 3 January 1991. In a letter dated 6 March 1991, the German government confirmed that the government recognition of 27 September 1956 remained valid and, in view of the country's reunification, now extended to the activities of the German Red Cross in the new federal Länder.

The first General Assembly of the reunified Society was held on 15 March 1991 to establish a new structure and elect new representatives. Botho Prince of Sayn-Wittgenstein is the President of the reunified Society, whose headquarters will be in Berlin although its secretariat will remain in Bonn at the following address: German Red Cross, Friedrich-Ebert-Allee 71, D-W-5300 Bonn 1.

New Statutes were drawn up and submitted to the Joint ICRC/League Commission on National Society Statutes in accordance with Resolution VI of the 22nd International Conference (Tehran 1973) and Resolution XX of the 24th International Conference (Manila 1981). The Commission has approved them.

The **Yemen Red Crescent Society** has informed the ICRC of the merger, on 18 July 1990, of the two former Yemeni Societies. At the new Society's first General Assembly, on 7 June 1991, Mr. Yehya Hussein Al-Arashi was

elected its President. The Headquarters of the Society is in Sana'a, at the following address: Yemen Red Crescent Society, Head Office, Building No. 10, 26 September Street, Sana'a.

The unification of these two National Societies means that there are now 147 National Societies members of the International Red Cross and Red Crescent Movement.

The International Committee of the Red Cross wishes the German Red Cross and the Yemen Red Crescent Society every success in the continuation and development of their humanitarian activities.

FOR THE INTERNATIONAL COMMITTEE  
OF THE RED CROSS

**Cornelio Sommaruga**  
*President*

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## **Recognition of the Solomon Islands Red Cross Society**

The International Committee of the Red Cross has recognized the Solomon Islands Red Cross Society.

This recognition, which took effect on 3 October 1991, brings to **148** the number of National Societies which are members of the International Red Cross and Red Crescent Movement.

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# **FAMINE AND WAR**

## **I. Introduction**

When famine breaks out during an armed conflict, the natural, spontaneous reaction is to help the victims by dispatching and distributing food.

Over the past ten years, considerable efforts have been made to improve such relief operations. But despite marked progress, and irrespective of whatever improvements might still be made, the fact must be faced that food aid alone will never eliminate famines nor the suffering they cause. It still falls short of meeting the victims' needs and appears essentially inadequate to solve their problems.

It is therefore necessary to analyse the precipitating factors of famine during armed conflicts so as to have a better understanding of the real nature of the problems involved and to determine how to adapt humanitarian responses accordingly.

It might at first sight seem difficult to prevent certain conflict situations from resulting in disastrous famines. However, a closer scrutiny of war/famine situations shows that in most cases famine is linked to disrupted access to sources of food that are usually available, rather than to their absence. Working on that basis, there are two approaches to humanitarian aid in war/famine situations, and in practice they are often complementary:

- The first approach consists in tackling the causes of famine by analysing why access to food has been disrupted and by proposing practical solutions to the problem;
- The second approach concerns food assistance as such, which should be seen as the last means of helping famine victims, to be resorted to once it becomes clear that normal access to food cannot be restored.

To examine these two approaches, the ICRC organized a seminar in Annecy (France) from 21 to 23 March 1991 on the subject "Famine and War". Its purpose was to collect data to define more clearly the

foundations of a global humanitarian policy for dealing with famine in armed conflicts.

The seminar was attended by some forty people invited in their personal capacity, on account of their experience of the war/famine problem from a particular viewpoint. Although their areas of experience varied they were considered complementary, e.g.:

- the phenomenon of famine;
- chain of information about famine, from the early warning stage to the event being reported in the media;
- international humanitarian law (IHL) and famine in armed conflict situations;
- relief operations.

## **II. The work of the seminar**

The seminar was extremely productive. The present article will, however, include only points of direct and immediate operational importance, i.e. the phenomenon of famine and IHL as it relates to famine during armed conflicts. The overall work of the seminar will later take the form of a detailed published report.

### **1. The phenomenon of famine<sup>1</sup>**

From what the experts had to say, it was clear that the word famine, taken in its strict definition as widespread death due to the lack of food, conveys only the most spectacular aspect of the phenomenon, namely that of disaster. Moreover, if humanitarian aid is governed by this definition, it arrives too late to be effective.

Famine has its own momentum, modulated by climatic and economic factors. It does not suddenly appear overnight, but develops gradually. Few famines are the immediate result of a single event. Hence the idea of an early warning system whereby a series of indicators are identified to detect impending famine as quickly as possible. Although this is a praiseworthy attempt at disaster prevention, it is undoubtedly in early detection, and in the measures it suggests, that the greatest number of problems are encountered:

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<sup>1</sup> Based on studies by John Seaman and Frances D'Souza.



- What most humanitarian organizations try to prevent is widespread loss of life through lack of food. Objectives and remedies are likely to be inappropriate because, although not all famines lead to the deaths of large numbers of people, they do all imply an impoverishment of the population. It is this impoverishment which must be tackled well in advance.
- Famine is a process which slowly renders ineffective the alternative plans that man develops to adapt to misfortunes. During the process, the community becomes more and more dangerously impoverished. Yet it is relatively rare that the final outcome is absolute destitution and death by starvation. The causes of famine may very well disappear at one phase of adaptation or another, and the problem is solved for the time being. This largely explains the poor performance of indicators.
- The appropriate response to the different aspects of famine is frequently complex and variable. Furthermore, since situations differ, it is almost impossible to devise an early warning system which can be applied universally.

It is therefore not easy for any organization to detect that famine is on the way, and above all to assess whether it will resolve itself on its own or whether it will end in disaster. Nevertheless, from the viewpoint of intervening on humanitarian grounds, the phenomenon of famine has at least three clear characteristics:

- (a) Adaptation to emergent famine can be detected by an economic analysis of the use of resources. This adaptation leads sooner or later to the impoverishment of the people concerned, which means they have less and less access to sources of food. The final stage is total destitution, with the population reduced to begging.
- (b) Many famines go unnoticed because they do not end in disaster. Either the causes of famine have disappeared sufficiently early or the authorities have taken adequate steps to ensure sufficient access to food until the crisis passes. It has been proved that effective action of this kind can be taken in peacetime only, and only when the government is open to democracy.
- (c) Most famines, especially those which kill, occur during armed conflicts. There is a very simple explanation: apart from those climatic and economic factors which generally give rise to famines, the loss of access to food resources is largely the result of intentional acts. These are mainly of two kinds:

- acts which directly or indirectly deprive the population of its own resources and of the means to adapt, for instance displacement of the population, restrictions on production activities, the severance of lines of communication and the pillaging and destruction of resources;
- acts which prevent access to food from being restored, such as those banning the provision of food aid, the transfer of resources and the creation of employment.

The fact that in 1987 the food system of seventeen countries with a combined population of 425 million people was severely disrupted because of war — either through deliberate acts of aggression or as the result of conflict — is a clear illustration of these phenomena.

This brings us to the second main subject of the seminar: IHL and famine during armed conflicts.

## **2. IHL and famine during armed conflicts<sup>2</sup>**

The key issue of the seminar was to study the balance between action to avert a crisis and action to limit damage once a disaster has occurred. In situations of armed conflict, loss of access to resources and the destitution that follows are generally the result of deliberate acts. Since, in general, all action is governed by legislation, what then are the legal safeguards to protect people against acts affecting their resources and against the ensuing destitution?

IHL is extremely clear in this connection:

- Starvation of civilians as a method of warfare is prohibited (Additional Protocol I, Article 54 (1));
- It is prohibited to attack, destroy, remove or render useless objects indispensable to the survival of the civilian population, such as foodstuffs, agricultural areas for the production of foodstuffs, crops, livestock, drinking water installations and supplies and irrigation works, for the specific purpose of denying them for their sustenance value to the civilian population or to the adverse Party, whatever the motive, whether in order to starve out civilians, to cause them to move away, or for any other motive (Additional Protocol I, Article 54 (2)).

Moreover, the corresponding provisions in Additional Protocol II are virtually the same.

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<sup>2</sup> Based on the paper by Peter Macalister-Smith.

- The displacement of the civilian population shall not be ordered for reasons related to the conflict unless the security of the civilians involved or imperative military reasons so demand. Should such displacements have to be carried out, all possible measures shall be taken in order that the civilian population may be received under satisfactory conditions of shelter, hygiene, health, safety and nutrition (Additional Protocol II, Article 17 (1)).
- It is recommended that, for the civilian population, relief actions which are exclusively humanitarian and impartial should be accepted when these people lack supplies essential for their survival (Additional Protocol I, Article 70; Additional Protocol II, Article 18).

Underlying this formulation is the principle that belligerents cannot legally use every possible means to place the enemy at their mercy. With regard to the civilian population, it is based on the established distinction between combatants and those not taking part in hostilities. This distinction - or principle - has become a legal prohibition, codified in Article 48 of Protocol I additional to the Geneva Conventions, that civilians shall not be the object of direct military attack. The prohibition also applies to civilian objects (Protocol I, Article 52).

Considering that IHL is a compromise between military requirements and humanitarian considerations, it is frequently difficult to apply *stricto sensu* the above-mentioned principles. The reasons are as follows:

- In modern warfare, virtually the whole of enemy territory and virtually the entire economic infrastructure may become a legitimate military target. As the law stands, the dividing line between what is military and what is civilian is extremely blurred.
- Objects which under normal circumstances are purely civilian in nature, even including crops and farmland, may legally become military objectives if a Party to a conflict uses them for military purposes.
- Since starvation is permitted as a method of combat against soldiers, this may incite them to attack and remove objects indispensable to the survival of civilians.

As a result, the “line of defence” of IHL frequently collapses. Relief operations then become necessary. The provisions of IHL concerning assistance to people in need are also an important means of giving substance to the principle of protection of the civilian population: assistance is the active counterpart of protection, and both

concepts are complementary and closely interlinked. As in providing protection against destitution, the provisions of IHL concerning humanitarian aid for the civilian population are relatively weak in the context of contemporary armed conflicts. Furthermore, putting these provisions into practice always involves a degree of interpretation of the law — generally in difficult circumstances.

The fact still remains that the principles which IHL defends render it a powerful tool. While flexible enough to adapt to each specific situation, it can be universally applicable. Persuasion should precede prohibition.

### III. Conclusions reached by the seminar

The working groups' main conclusions were as follows:

#### 1. Background

- The terms “*famine*”, “*assistance*” and “*violence*” cover a wide range of concepts, facts and activities that cannot be encompassed by any narrow definition.
- Humanitarian organizations are increasingly faced with situations which have the following characteristics:
  - War is an important factor favouring the emergence of famine and limiting the possibilities for taking remedial action.
  - The warring parties have difficulty in perceiving the civilian population and humanitarian assistance as unrelated to any military interest.
  - Too often, the *raison d'être* of military operations is to destroy the population's livelihood, not merely to attack strictly military objectives.
  - Under the threat of famine, people fear destitution as much as starvation.
  - Destitution results from attacks on resources, social structures and the peoples' cultural identity, and the accentuation of this trend is resulting in a growing synergism of famine and hostilities.

## **2. Practical consequences**

- Humanitarian assistance should try to combat the progressive destitution caused by armed conflict.
- The victims in need of assistance are those who are reduced to a state of destitution by the warring parties. In its most extreme form, this destitution is characterized by a high mortality rate.
- The objective of humanitarian assistance is not only to keep people alive, but to keep them alive for a viable future; that is to secure them a sustainable livelihood.
- Owing to the reality of warfare, protection and assistance are inevitably and inextricably linked.
- Warring parties' perception of humanitarian assistance is changing. Of necessity, humanitarian agencies are having to reassess the way in which they conduct their activities.
- Access to the victims remains the main problem of any humanitarian operation.
- To implement policies geared to any given situation, the ability to identify needs and to take practical action to address those needs is essential.

## **3. Consequences for IHL**

More specifically as regards IHL, the participants came to the following main conclusions:

- Compliance with the rules of IHL is a key to preventing famine during armed conflicts; food aid should be considered only as the last resort when the belligerents fail to abide by IHL.
- Respect for the rules of IHL diminishes the risk of famine. However, this alone cannot completely eliminate such risk, nor can it supply all the means required for effective assistance.
- The displacement of persons is a factor which engenders or aggravates famine. Respect for the rules of IHL could in many cases prevent such displacements.
- Starvation of military personnel as a method of combat is not prohibited. However, it may incite them to steal food and to use any means possible to obtain it. This point should be considered for the future development of IHL.
- Donors should not withhold food aid as a means of putting pressure on the authorities to show better respect for IHL. The civilian population would be the first victims of such a measure. Furthermore, donors should be urged not to wait until civilians are dying of starvation before taking appropriate action.

- Emphasis should be placed on the dissemination of IHL in peacetime and a system for dissemination among NGOs working in war situations should be set up.
- Also for dissemination purposes, the dialogue between the ICRC, other organizations and the armed forces should be intensified with reference to the problem of famine during armed conflicts. It is essential to convince the military that respect for the rules of IHL is in no way contrary to their military interests.

#### **IV. General conclusion**

In addressing the phenomenon of famine and the relevant parts of IHL, the seminar “Famine and War” had several merits:

- It pinpointed the exact nature of needs arising from famine during armed conflict.
- It identified the limits to food aid while also demonstrating that a many-sided approach, ranging from protection to assistance, is needed to curb the process leading to destitution.
- It made it clear that merely to keep people alive is not enough; on witnessing their destitution, responsibility must be assumed for ensuring, directly or indirectly, that they have the prospects of a viable future.
- It gave prominence again to protection as a measure to avert famine, a factor which is generally overlooked or neglected. Undoubtedly this is the most difficult approach and requires the greatest courage.
- It gave a reminder that one of the primary tasks of the Red Cross and Red Crescent is to disseminate knowledge of IHL and to seek to obtain compliance with it. Popular and readily acceptable relief operations are in fact nothing better than failures when they serve to palliate violations of the principles of IHL.

The seminar “Famine and War” will certainly be followed up:

- A draft resolution will be submitted to the 26th International Conference of the Red Cross and Red Crescent restating the main aspects of the work of the seminar with regard to IHL’s basis, role and potential for protecting famine victims during armed conflict.
- An in-depth report will be published on the work of the seminar.

- A complete analysis will be made of the seminar's findings in order to lay the foundations for a global humanitarian policy on famine during armed conflicts.
- Informal working relations will be established with the participants so as to continue examining the problem of famine and war. This is essential in view of the speed with which the modern world is changing.

**Alain Mourey**

*Nutritionist*

*Medical Division ICRC*

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## Australia ratifies the Protocols

On 21 June 1991, Australia ratified the Protocols additional to the Geneva Conventions of 12 August 1949 relative to the protection of victims of international (Protocol I) and non-international (Protocol II) armed conflicts, adopted in Geneva on 8 June 1977.

The instrument of ratification was accompanied by various declarations, the text of which is given below:

### DECLARATIONS IN RELATION TO PROTOCOL I

*In depositing its instrument of ratification for Protocol I, Australia hereby makes declarations of understanding in relation to Articles 5, 44 and 51 to 58 inclusive of the said Protocol.*

*It is Australia's understanding that in relation to Article 5, with regard to the issue whether, and in what measure, Protecting Powers may have to exercise any functions within the combat zone (such as may be implied by provisions in Parts II and IV of the Protocol), the role of the Protecting Power will be of a like character to that specified in the First and Second Conventions and Part II of the Fourth Convention, which apply mainly to the battlefield and its immediate surroundings.*

*It is the understanding of Australia that in relation to Article 44, the situation described in the second sentence of paragraph 3 can exist only in occupied territory or in armed conflicts covered by paragraph 4 of Article 1. Australia will interpret the word "deployment" in paragraph 3(b) of the Article as meaning any movement towards a place from which an attack is to be launched. It will interpret the words "visible to the adversary" in the same paragraph as including visible with the aid of binoculars, or by infra-red or image intensification devices.*

*In relation to Articles 51 to 58 inclusive it is the understanding of Australia that military commanders and others responsible for planning, deciding upon, or executing attacks, necessarily have to reach their decisions on the basis of their assessment of the information from all sources, which is available to them at the relevant time.*



*In relation to paragraph 5(b) of Article 51 and to paragraph 2(a)(iii) of Article 57, it is the understanding of Australia that references to the "military advantage" are intended to mean the advantage anticipated from the military attack considered as a whole and not only from isolated or particular parts of that attack and that the term "military advantage" involves a variety of considerations including the security of attacking forces. It is further the understanding of Australia that the term "concrete and direct military advantage anticipated", used in Articles 51 and 57, means a bona fide expectation that the attack will make a relevant and proportional contribution to the objective of the military attack involved.*

*It is the understanding of Australia that the first sentence of paragraph 2 of Article 52 is not intended to, nor does it, deal with the question of incidental or collateral damage resulting from an attack directed against a military objective.*

In accordance with their provisions, the Protocols will come into force for Australia on 21 December 1991.

Australia is the **103rd** State to become party to Protocol I and the **93rd** to Protocol II.

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## **Declaration of succession of the Republic of Namibia to the Geneva Conventions**

On 22 August 1991, the Republic of Namibia deposited a declaration of succession to the four Geneva Conventions of 12 August 1949 with the Swiss Government. The Conventions had already been in force in Namibian territory (formerly South West Africa) since 31 March 1952 by virtue of the Republic of South Africa's accession to them.

In accordance with international practice, the entry into force in Namibia of the four Conventions is retroactive to 21 March 1990, the date on which the country became independent. The accession to the Conventions, which was made on Namibia's behalf by the United Nations Council for Namibia on 18 October 1983, is therefore no longer applicable.

The Republic of Namibia is the **166th** State to become party to the Geneva Conventions.

## DISASTER MEDICINE

From the abundant writings on disaster relief, the *Review* has selected for its readers two works that will serve as a useful complement to this issue's articles on health care and medical assistance in disaster situations.

*New Aspects of Disaster Medicine* covers the proceedings of the First Asian-Pacific Conference on Disaster Medicine (1988).<sup>1</sup> Held under the auspices of the Japanese Association for Acute Medicine and the Japanese International Cooperation Agency, the Conference brought together experts and government representatives from some 20 mainly Asian and Pacific countries and from national and international relief organizations.

The ICRC and several Asian Red Cross Societies also took part in the meeting, which dealt with international cooperation in disaster medical activities, emergency medical services, disaster preparedness and response, experience of disaster relief activities, and finally rescue and medical care in the event of aircraft accidents or disasters at airports.

This book contains a very wide variety of contributions. Most of them describe experience gained in large-scale disasters (the drought in Ethiopia, the 1985 earthquake in Mexico, the destruction of the town of Armero in Colombia by a volcanic eruption in 1985, the Zeebrugge disaster of 1987, etc.) and medical and paramedical action taken in the wake of less extensive disasters. The book also contains the texts of talks on organization, structure and working methods from a large number of public and private institutions involved in disaster medicine in China, Indonesia, Singapore, Thailand, Japan, Malaysia and elsewhere.

The speakers point out both the strong and weak points of each phase of the respective operation under review (preparation, organization, structure, execution during the emergency itself and rehabilitation of the survivors), draw conclusions and make useful recommendations which may be summarized as follows:

- Adopt a multidisciplinary approach to disasters and mobilize the appropriate manpower resources to respond to the needs that arise (first-aid workers, doctors, nurses, nutritionists, primary health-care workers, etc.).

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<sup>1</sup> *New Aspects of Disaster Medicine — Proceedings of the Asian-Pacific Conference on Disaster Medicine* (Osaka, Japan, 24-26 November 1988), Editors: Muneo Ohta, Takashi Ukai, Yasuhiro Yamamoto, Herusu Publishing Co. Inc., Tokyo, 1988, 222 pp.

- Make good use of modern technology to detect approaching natural or technological disasters, and get to know more about the characteristics of each disaster in order to avert the epidemics often associated with them.
- Develop preventive systems: the higher the degree of preparation and planning — in particular coordination between the security forces, civil defence organizations, the Red Cross or Red Crescent, fire brigades, voluntary agencies, etc. - the more effective the relief operation will be. The need to improve pre-hospital medical care was also stressed.
- Involve local communities more in disaster management to make them as self-sufficient as possible when disasters strike. The role of properly trained volunteers was reaffirmed and it was recommended that the training of medical and paramedical teams should be improved (special mention being made of psychological assistance to victims).
- Improve coordination between the mechanisms of international aid: inter-governmental organizations, the International Red Cross and Red Crescent Movement, the NGOs and bilateral assistance. To this end, it was recommended that universally recognized principles for such operations should be adopted.

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A relief operation is made possible by the commitment of institutions and individuals from different countries, speaking different languages and working according to their own rules and customs. Communication difficulties between the various entities involved may affect the operation's effectiveness.

Experience has demonstrated the need to provide doctors, engineers, meteorologists, nurses, nutritionists, planners and everyone else involved in disaster preparedness, relief and rehabilitation with a terminological guide to facilitate communication between them. This dictionary<sup>2</sup>, compiled by Dr. S.W.A. Gunn, former head of Emergency Relief Operations at WHO and president of the Mediterranean Burns Club, thus contains definitions of the specialized terms often used in disaster-relief programmes and their equivalents in several major languages. Its purpose is to enable relief workers to select terms that will be understood by all.

It is divided into four sections, one for each of the four languages: English, French, Spanish and Arabic. Each section is divided into three parts. First there is the "dictionary" (providing the definition for each term in the case of English) which gives its equivalent in the three other languages. The second section is "units and measures", again providing a definition of each

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<sup>2</sup> S.W.A. Gunn, *Multilingual Dictionary of Disaster Medicine and International Relief*, Kluwer Academic Publishers, Dordrecht, London, Boston, 1990, 190 pp.

unit in English and the equivalent in the various languages. Finally there is a list of “acronyms and abbreviations”.

This dictionary is a useful tool not only for those practising disaster medicine itself but also for researchers and translators who, puzzled for example by “GOES”, will quickly discover that it stands for “Geostationary Operational Environmental Satellite”, or, in French, “Satellite d’exploitation géostationnaire pour l’étude du milieu”, or, in Spanish, “Satélite geostacionario operacional para el estudio del medio ambiente”.

*Jacques Meurant*

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## ARTICLES SUBMITTED FOR PUBLICATION IN THE *INTERNATIONAL REVIEW OF THE RED CROSS*

The *International Review of the Red Cross* invites readers to submit articles relating to the various humanitarian concerns of the International Red Cross and Red Crescent Movement. These will be considered for publication on the basis of merit and relevance to the topics to be covered during the year.

- Manuscripts will be accepted in *English, French, Spanish, Arabic or German*.

**Texts should be typed, double-spaced, and no longer than 25 pages (or 6 000 words). Please send diskettes if possible.**

- Footnotes (*no more than 40*) should be numbered superscript in the main text. They should be typed, double-spaced, and grouped at the end of the article.
- Bibliographical references should include at least the following details: (a) for books, the author's initials and surname (in that order), book title (underlined), place of publication, publishers and year of publication (in that order), and page number(s) referred to (p. or pp.); (b) for articles, the author's initials and surname, article title in inverted commas, title of periodical (underlined), place of publication, periodical date, volume and issue number, and page number(s) referred to (p. or pp.). The titles of articles, books and periodicals should be given in the original language of publication.
- Unpublished manuscripts will not be returned.
- Published works sent to the editor will be mentioned in the list of publications received and, if considered appropriate, reviewed.
- Manuscripts, correspondence and requests for permission to reproduce texts appearing in the *Review* should be addressed to the editor.

**Articles, studies, and other signed texts from non-ICRC sources published in the *Review* reflect the views of the author alone and not necessarily those of the ICRC.**

JUST PUBLISHED

**PAMPHLETS FOR THE GENERAL PUBLIC  
ON THE MAJOR TOPICS TO BE DISCUSSED  
AT THE 26th INTERNATIONAL CONFERENCE  
OF THE RED CROSS AND THE RED CRESCENT**

The ICRC's Communications Department has just published a series of seven pamphlets for the general public on the major topics to be discussed at the 26th International Conference, due to be held in Budapest in November/December. The subjects covered are:

- *An introduction to the 26th International Conference of the Red Cross and the Red Crescent*
- *International humanitarian law and armed conflicts — application of the law would prevent untold suffering*
- *Breaking the spiral of senseless destruction and suffering — the ICRC and the arms debate*
- *War at sea is still governed by law dating from 1907 — humanitarian principles in the age of radar transponders*
- *Visual identification is no longer enough — better protection for medical transports*
- *Safety on humanitarian missions*
- *The ICRC worldwide 1987-1991.*

These texts, written by Françoise Bory, are published in *English, Arabic, French, and Spanish*, and are available from the ICRC's Publishing and Documentation Service.

**THE ICRC'S 1990 REFERENCE REPORT**

The ICRC has just published its *1990 Reference Report*, which reviews all the activities conducted by the institution last year, ranging from protection and assistance operations for civilian and military victims of armed conflict and internal disturbances to work on international humanitarian law and the Red Cross and Red Crescent principles and support activities at Geneva headquarters.

The *1990 Reference Report* supplements the *Annual Report 1990*, which came out earlier this year in the form of a brief overview with financial tables.

The *1990 Reference Report* is published as an addition to the *Review* collection and is available in *English, French, Spanish, German and Arabic*. It has 120 pages and may be obtained from the ICRC's Publishing and Documentation Service.

The ***International Review of the Red Cross*** is the official publication of the International Committee of the Red Cross. It was first published in 1869 under the title "Bulletin international des Sociétés de secours aux militaires blessés", and then "Bulletin international des Sociétés de la Croix-Rouge".

The ***International Review of the Red Cross*** is a forum for reflection and comment and serves as a reference work on the mission and guiding principles of the International Red Cross and Red Crescent Movement. It is also a specialized journal in the field of international humanitarian law and other aspects of humanitarian endeavour.

As a chronicle of the international activities of the Movement and a record of events, the ***International Review of the Red Cross*** is a constant source of information and maintains a link between the components of the International Red Cross and Red Crescent Movement.

The ***International Review of the Red Cross*** is published every two months, in four main editions:

French: REVUE INTERNATIONALE DE LA CROIX-ROUGE (since October 1869)

English: INTERNATIONAL REVIEW OF THE RED CROSS (since April 1961)

Spanish: REVISTA INTERNACIONAL DE LA CRUZ ROJA (since January 1976)

Arabic: المجلة الدولية للصليب الأحمر

(since May-June 1988)

Selected articles from the main editions have also been published in German under the title *Auszüge* since January 1950.

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The **International Committee of the Red Cross (ICRC)**, together with the League of the Red Cross and Red Crescent Societies and the 148 recognized National Red Cross and Red Crescent Societies, is one of the three components of the International Red Cross and Red Crescent Movement.

An independent humanitarian institution, the ICRC is the founding body of the Red Cross. As a neutral intermediary in case of armed conflict or disturbances, it endeavours on its own initiative or on the basis of the Geneva Conventions to protect and assist the victims of international and civil wars and of internal troubles and tensions, thereby contributing to peace in the world.

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# INTERNATIONAL REVIEW

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*Special*

**HEALTH PROTECTION  
AND MEDICAL ASSISTANCE  
IN DISASTER SITUATIONS**

**Famine and war**

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**Apropos of the 26th International Conference  
of the Red Cross and Red Crescent**